CANADIAN SKI GUIDE ASSOCIATION

Policy No. 100012146 issued by Industrial Alliance Insurance and Financial Services Inc.

DIAGNOSTIC AND SPECIALIST ACCESS INSURANCE

COVERAGE

Coverage is applicable to diagnostic examinations (MRI and CT scans) and specialist consultations delayed due to placement on a procedural waiting list in Canada.

ELIGIBILITY

You are eligible as an Insured Person if you are an employee under age 75, reside in Canada, are covered under the provincial health insurance plan of your province of residence, and are working 20 hours or more per week at full pay. Your spouse under age 75 and unmarried dependent children are eligible if you submit an application to your employer. Unmarried children are those under age 21 or to age 25 if attending college or other school in Canada on a full-time basis and are dependent on your support.

BENEFITS AND SERVICES

1. Diagnostic Procedures

Approved medically necessary diagnostic procedures related to conditions or treatment. Covered diagnostic procedures are limited to the following:

a) Magnetic Resonance Imaging (MRI)

b) Computerized Axial Tomography (CAT or CT scans)

2. Medical Referrals

Claims at TuGo will schedule appointments for an approved procedure, coordinate the diagnostic procedure and make any travel arrangements, if necessary. Requests for a specific medical clinic or physician may be considered and must be approved in advance by the insurer.

3. Transportation

Transportation costs incurred while travelling to and from the approved diagnostic facility will be reimbursed upon completion of an authorized diagnostic procedure or medical referral.

LIMITED SPECIALIST COVERAGE BENEFIT

If you, your insured spouse or insured dependent child are referred by your, your insured spouse's or insured dependent child's general practitioner (G.P.) to a specialist physician for assessment and the specialist physician confirms that the assessment cannot be provided within 21 consecutive days of the referral by the G.P., the cost of an assessment by an approved specialist physician will be paid, subject to the following:

(a) the referral by the G.P. is to a specialist physician in one of the following medical specialties: Cardiology, Ear, Nose and Throat, Gastroenterology, General Surgery, Neurology, Ophthalmology, Orthopedics, Rheumatology, Spine Team, and Urology; and

(b) the assessment is for the purpose of determining a condition which may result in a diagnostic test.

Claims at TuGo will make the first available appointment with the appropriate specialist physician at the geographical location closest to you, your insured spouse or insured dependent child and make every effort to schedule the special physician assessment within 21 days from the referral by the G.P. and/or approval of the request.

DIAGNOSTIC AND SPECIALIST ACCESS INSURANCE (Continued…)

BENEFITS AND SERVICES (CONTINUED…)

LIMITED SPECIALIST COVERAGE BENEFIT (CONTINUED…)

The Limited Specialist Coverage Benefit provides for a maximum of two assessments per person per coverage period. Each assessment includes an initial and follow-up consultation.

CONTINUATION OF INSURANCE DURING A LEAVE OF ABSENCE

Your coverage under the policy may be continued during any approved general leave of absence with no increases or changes during the term of the leave, subject to a maximum duration of six consecutive months and provided payment of premium is continued.

Your coverage under the policy may be continued during any approved maternity or parental leave with no increases or changes during the term of the leave, subject to the maximum duration permitted by the applicable provincial Employment Standards Legislation and provided payment of premium is continued.

LIMITATIONS

1. **Lifetime Maximum**
   Benefits are provided to an overall lifetime maximum of $1,000,000.00 U.S. per person.

2. **Pre-Existing Condition Limitation**
   Benefits for Diagnostic and Specialist Access Insurance are limited for any pre-existing condition that existed during the 24 months prior to your, your insured spouse's or insured dependent child's effective date of coverage. Diagnostic and Specialist Access Insurance coverage is not provided for any pre-existing condition until after you, you insured spouse or insured dependent child have been continuously insured for 24 months under the policy.

3. **Benefit Maximum**
   Benefits payable under the policy for medical and/or medical clinic expenses in respect to you, your insured spouse or insured dependent child are limited to the Maximum Amount Payable.

   "Maximum Amount Payable" whenever used means the fee negotiated between the physician, medical clinic or outpatient surgical facility and the insurer and **Claims at** TuGo.

4. **Benefits not Provided in Province of Residence**
   You, your insured spouse or insured dependent child are not entitled to receive benefits under the policy for services and supplies that are provided in your, your insured spouse's or insured dependent child's province of residence.

EXCLUSIONS

This policy does not provide Diagnostic and Specialist Access Insurance benefits for the following:

1. Services and supplies that are:
   (a) not medically necessary;
   (b) not recommended or approved by a Physician;
   (c) not rendered within the scope of the Physician's license;
   (d) furnished by a government plan, Medical Clinic or institution unless the Insured Person is legally required to pay for the services;
   (e) charged in excess of the Maximum Amount Payable;
   (f) provided without prior written Pre-Authorization by Us; or
   (g) provided after the termination date of an Insured Person's Diagnostic and Specialist Access Insurance.
2. Injury or Sickness occurring during or arising from an Insured Person's course of employment for which benefits are provided or payable under Workers' Compensation or under any act or law which provides benefits for such Injury or Sickness for which an Insured Person failed to file a claim for Workers' Compensation benefits for which they were eligible.
3. Injury or Sickness caused by: an act of declared or undeclared war; service in the military forces of any country, including non-military units supporting such forces; the Insured Person committing or attempting to commit civil tort or an indictable offence or taking part in a riot (meaning the Insured Person is taking an active part in common with three or more others by using or threatening to use force or violence without authority of law).
4. Injury or Sickness, while sane or insane, resulting from or related to self-inflicted Sickness or Injury, flagrant self-abuse such as continued behaviour contrary to a Physician's recommendation, suicide, threatened suicide, alcohol abuse, or drug addiction or abuse. This includes an accident where alcohol or drugs were involved; treatment related to any psychological, mental or emotional disorders or treatment of any sexually transmitted disease.
5. Procedures, devices, services, supplies, or drugs that We consider experimental or investigative because they are:
   (a) considered as such by protocol of the U.S. Department of Health and Human Services or any of its subsidiary agencies; or
   (b) not formally approved by the U.S. Federal Drug Administration, American Medical Association, or the National Institute of Health for that particular diagnosis or specific treatment prescribed; or
   (c) primarily used in the laboratory or research setting that has and/or have progressed to only limited human use.
6. Treatment to remove a birthmark;
7. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs;
8. Routine physical exams, checkups, and related x-ray and lab expenses, drugs and medicines, except those prescribed in and taken home from the Hospital where permission was Pre-Authorized by Us;
9. Blood products storage where not necessary or not in conjunction with a scheduled covered surgery;
10. Blood products when replaced by donation;
11. Organ or tissue or transplants, including transplants for burns and related services, except corneal transplants;

EXCLUSIONS (CONTINUED…)

12. The implant of an artificial organ or any service or supply in connection therewith;
13. Items or devices primarily used for comfort or commonly installed in homes, including but not limited to air purifier, humidifier, dehumidifier, whirlpool, air conditioning, water bed, exercise equipment or ultraviolet lighting;
14. Personal or home-based artificial kidney equipment;
15. Growth hormone treatment, regardless of the reason for prescription;
16. Foot care including but not limited to: shoe inserts, foot care related to corns, calluses, bunions, hallux valgus, flat feet, weak arches or weak feet;
17. Treatment or surgery of bony protuberance of the forefoot and toes, including misalignment of the same (i.e., bunions, spurs, hammertoes);
18. Any dental treatment or services;
19. Treatment of temporomandibular joint dysfunction, craniomandibular joint dysfunction, myofacial pain syndrome and all related conditions, orthognathic reconstructive surgery;
20. Private duty services of a health care provider;
21. Eye exams for corrective lenses, including contact lenses, eye glasses and their fitting, radial keratotomy, corneal modulation, refractive keratoplastry or any similar procedure, speech or vision therapy, including eye exercises, hearing exams, hearing aids and their fitting;
22. Emergency medical care provided through a public or private medical facility;
23. A Chronic Medical Condition;
24. A Related Medical Condition;
25. Sex change operations and complications from that surgery, artificial insemination, in-vitro or in-vivo fertilization, testing, treatment or medication for the primary purpose of achieving conception, maintaining pregnancy or preventing abortion, infertility and impotency testing and treatment, abortion, voluntary sterilization, reversal procedures or sterilization;
26. Acupuncture, chelation therapy, or laetrile used in form or any derivative or variation thereof;
27. Treatment for weight loss, or for exogenous or morbid obesity, including but not limited to: gastric bypass, gastric stapling, or balloon catheterization, liposuction or reconstructive surgery, any food supplement or augmentation, diet, health or exercise programs, health club dues, or weight reduction clinics;
28. Any treatment related to pregnancy or complications thereof;
29. Prosthesis, corrective devices and medical appliances which are not surgically required, unless necessitated by Injury, deformity or Sickness which occurs while the Insured Person is covered under the policy;
30. Chronic Fatigue Syndrome including, but not limited to diagnostic workups;
31. Sclerotherapy, for the treatment of varicose veins of the extremities;
32. Any treatment relating to birth defects or congenital illnesses;

EXCLUSIONS (CONTINUED…)

33. Services and supplies (including but not limited to splints and braces) prescribed or rendered solely to allow for participation in any sports related activity, or solely for strengthening, conditioning or maintaining a muscle, bone or joint function;
34. Injury or Sickness occurring while engaged in any hazardous, high risk or extreme sport activities including but not limited to: sky or scuba diving, parachuting, mountain climbing, ballooning, hang gliding, bungee cord jumping, stunt flying, crop dusting or the operation of an ultra light aircraft, racing of any form (other than on foot) and all professional sports.
35. Expense for which no benefit is specifically described in the policy, in any amendment to the policy, or an expense specifically excluded in the policy.

CLAIMS PROCEDURES

You should provide notice of claim not later than 30 days from the date a claim arises under the policy on account of injury or sickness by phoning **Claims at** TuGo at 1-866-602-7379.

You must produce any documentation required by **Claims at** TuGo to enable them to process and confirm your eligibility of the claim. All required documentation must be provided within 90 days from the date a claim arises under the policy and in no event beyond 12 months from the date of loss.

To qualify for reimbursement of eligible expenses, you must provide original, itemized receipts within 12 months from the date the expense is incurred.