iMED Plan Member Booklet

University of British Columbia

iMED Health Insurance for *New* International Students

This booklet applies to plan members under
Group Policy PM8686125

For all claims inquiries and emergency assistance, contact **MSH Assistance**.

[For all iMED **enrolment** inquiries, contact David Cummings Insurance Services Ltd.]

In addition to detailing the terms and conditions of your insurance, the purpose of this booklet is to provide you with a comprehensive description of the iMED program, including practical guidance for accessing medical services and using your insurance successfully.
Please read this booklet and keep a copy handy so that you can refer to it when needed.

All amounts indicated in this document are expressed in **Canadian dollars**, unless otherwise specified.

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MEDICAL EMERGENCIES

MSH Assistance (open 24/7)
+1 (800) 808 2694 *(from Canada and United States)*
+1 (403) 538 2364 *(collect to Canada from anywhere else in the world)*
mshassistance@mshassistance.com

When you are faced with a **serious medical emergency***, following the below steps

» Call 911 for ambulance service in Canada or go to the nearest hospital.

» Show your iMED insurance wallet card upon hospital registration.

STUDY PERMIT HOLDERS TAKE NOTE!
Upon admission to a hospital in **British Columbia, Canada** (including an Out-patient Emergency Ward) students who hold a Study Permit valid for six months or longer **must** present a copy of their Study Permit in order to be charged the appropriate (lower) hospital rates for "Un-Insured Residents." Otherwise, you will be charged much higher hospital rates for "Non-residents." If you do not have a copy of your study permit at time of hospital admission you may provide a copy to the hospital billing department afterward to have your patient account adjusted.

» If you are admitted as an **in-patient** you (or someone on your behalf) **must** contact MSH Assistance immediately, or **within 72 hours of admission**. An MSH case manager will work with the hospital to coordinate a direct billing of your patient account, subject to hospital approval. MSH will issue a pre-authorization letter based on the medical and billing information provided, and based on the terms and conditions of your health insurance policy.

***For routine medical care and treatment of minor ailments** that can be safely treated outside of a hospital, please refer to the **Orientation to Getting Health Care with iMED** on pages 28 – 29 of this booklet, and visit the *Get Health Care* page of the iMED website.

MEDICAL PRE-CERTIFICATIONS

Pre-certification (or prior authorization) helps to ensure that a major medical service or treatment meets your plan's guidelines before it is provided, and is required for certain medical services. To ensure a timely pre-authorization, request pre-certification as soon as possible by emailing all relevant details to mshassistance@mshassistance.com or start the process by calling MSH Assistance at the numbers provided above. Requests are processed within 3 to 5 business days for non-emergency cases.

MEDICAL EVACUATION & REPATRIATION

If medical evacuation or repatriation is needed, pre-authorization by MSH is **required**.

Call the MSH Assistance 24/7 Call Centre at the contacts above, or on your iMED insurance ID.

» MSH Assistance representatives are here for you, 24/7. Assistance is provided for medical evacuation or transport, hospital admission, ambulance service, family transportation to your bedside and repatriation. (Services are subject to certain conditions, limitations, and exclusions)

GEOGRAPHICAL AREA OF COVERAGE

ZONE OF COVERAGE: WORLDWIDE

***Worldwide**: as applicable to the Geographical Area, worldwide comprises all countries throughout the world.

COVERAGE DURING A TEMPORARY VISIT TO HOME COUNTRY

After the later of the commencement of foreign study assignment and the Effective Date, Emergency medical care may be covered for an unforeseen Sickness, Injury, or Accident that occurs during a Temporary Visit to the Insured Person's Home Country, subject to meeting the criteria and conditions of the policy definition of Temporary Visit to Home Country.

Temporary Visit to Home Country means a temporary visit or visits to one's Home Country that occurs during the Coverage Period, after the Insured has commenced residing in the country of foreign study assignment. Coverage during a Temporary Visit to Home Country is restricted to Emergency medical care for an unforeseen sickness, injury or accident. Routine Care for a pre-existing medical Condition is not covered during a Temporary Visit to Home Country. Unless pre-approved in writing from the Insurer, or its authorized representative, coverage during a Temporary Visit to Home Country cannot exceed the **cumulative** maximum of 15 days during the Coverage Period.

EFFECTIVE DATE AND POLICY TERM

This policy takes effect at 12:00 a.m., local standard time on the date stated in the application for coverage or the date coverage is approved by the Insurer and from which date all insurance months shall be calculated. It continues in force for the period for which premium has been paid. Coverage may be renewed subject to approval by the Insurer for further consecutive terms, not exceeding twelve (12) months, on payment of premium at the rate and in the amount determined at the time of renewal by the Insurer.

HIGH RISK COVERAGE

The Insurers reserve the right to exclude or surcharge coverage in countries deemed to be locations of extreme risk. Locations of extreme risk are subject to change based on the Insurer's assessment. Advance notification of fifteen (15) days will be provided by MSH INTERNATIONAL(CANADA) LTD. to policyholders with plan members in locations deemed to be of extreme risk before any surcharge becomes applicable.

TERMINATION COVER

The insurance of an Insured Person shall terminate on the earliest of the following:

- At termination date as stated on the certificate of insurance
- The date this policy is terminated;
- The date that any premium required or due on the part of the Insured Person remains unpaid;
- The date that the Insured Person reached age 65;
- The date that the Insured Person no longer meets the Eligibility requirements as stated in the Policy or as approved by the Insurer;
- The date the insured Dependent ceases to be an eligible Dependent as defined by this policy.
- The date You permanently return to your Home Country or Primary Place of Residency, or
    - For Insured Persons permanently returning to their Home Country or Primary Place of Residency, a maximum of 90 consecutive days from the date of return provided premium has been paid to cover this period.

Termination of the insurance of any Insured Person will not prejudice consideration of any claim that may have occurred prior to such termination.

Automatic Continuation of Coverage: If the Insured Person is unavoidably delayed for a reason in no way attributable to the Insured Person, beyond the end of the Coverage Period, this policy will automatically remain in effect at no extra premium for a period not to exceed:

1. 72 hours, if delayed while traveling as a fare paying passenger in a licensed public conveyance or by private vehicle and the delay is caused by mechanical breakdown, a traffic Accident or inclement weather; or
2. the period of confinement as an Inpatient in a Hospital OR the period during which You are unable to travel on medical grounds acceptable to the Claim Administrator. Following discharge from Hospital or following medical approval to travel, an additional 72-hour extension will be granted.

TERMINATION OF MASTER POLICY

This master policy may be terminated by either party with prior notice provided at least 120 days in advance of the requested termination date. Insured Persons enrolled prior to the termination of the master policy shall remain in force until the policy term end date and shall not be renewed after termination of the policy. Full premiums will be required for the entire policy term.

TERMINATION BY THE INSURED PERSON

Subject to approval by the Subscribing University, the Plan Administrators (David Cummings Insurance Services Ltd. and MSH International (Canada) Ltd.), and the Insurer, the Insured Person may request termination of this contract for reasons of becoming ineligible by giving written notice of termination to the Plan Administrator acting on behalf of the Insurer, or by delivery thereof to an authorized agent (e.g., school or organization). If this policy is cancelled prior to the Effective Date, the Insured Person will receive a full refund of premiums paid on a pro-rata basis. If this policy is cancelled after the Effective Date, the Insurer will refund the premiums paid subject to proof of existing equivalent coverage being in place. Refunds are subject to no claims having been incurred, paid, or pending. A waiting period of 90 days applies to all refunds and a minimum retention of three months premium may apply.

ELIGIBILITY

PRIMARY INSURED PERSON

For the purposes of this policy, the primary Insured Person shall be considered as those persons who:

- Are enrolled as a student, on foreign assignment or travelling outside of their Home Country for an accredited educational facility.
- Are a member of the Subscribing university.
- Are eligible Dependents of the Insured Person as defined by this policy.
- Are under age 65;
- Have been enrolled under this Policy.
- Have requested and received approval for extension of coverage upon termination of assignment and while traveling back to Home Country and have paid premium for this period or have had the premium paid on their behalf.

DEPENDENTS

For the purposes of this policy, Dependents shall be considered as those persons who are:

- The spouse or common law spouse (including same sex) of an insured person but excluded those legally separated, and under the age of 65.
- Unmarried children, stepchildren, foster children, legally adopted children, and children under legal guardianship or custody, who are accompanying the primary insured person outside of their home country and who are dependent on the insured person for support, provided that such children are not less than 15 days old and not more than 18 years old (or not more than 24 years old provided it can be provided that the child is continuing in full-time education).
- Unmarried children, stepchildren, foster children and legally adopted children Who care accompanying the primary insured person outside of their home country, and who are dependent on the insured person for support due to physical or mental disability.

OTHER INSURANCE

If, at the time of loss, the Insured Person has insurance from another source for Benefits provided under this policy, the policy with the earliest Effective Date will be deemed to be first payor. Any Benefits payable by the following shall not be considered as a covered cost under this policy:

- Any group or individual Hospital or medical plan.
- Any government Hospital or medical plan.
- Any Worker's Compensation Act.
- Any public or tax-supported agency.

GENERAL POLICY EXCLUSIONS

This policy does not cover expenses caused or contributed to directly or indirectly by:

1. Elective medical treatment.
2. Medication commonly available without a prescription; contraceptives, vitamin preparations; or medication received on a preventive basis that is not deemed Medically Necessary due to a preexisting Sickness or Injury. This includes but is not limited to vaccinations and immunizations except as provided under the Well Baby Care provision of this policy.
3. The Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency HIV/AIDS Coverage Benefit, except as provided under the HIV/AIDS Benefit.
4. Air travel, other than as a passenger in a certified commercial aircraft that provides passenger service and complies with government regulations concerning pilot licensing and current certificates of airworthiness.
5. Active participation in war or any act of war, or radioactive contamination.
6. Committing or attempting to commit any criminal act.
7. Termination of pregnancy, Except in the case of a major, vital complication which presents a clear and significant risk of death to the mother.
8. Hang gliding, paragliding, sport parachuting, sky diving, athletic or sports activities for remuneration or prize money, or while riding or driving in or on any motorised vehicle or device in any race of speed contents; scuba diving at a depth greater than 15 meters, and rock or precipice climbing at a height greater than 15 meters;
9. Intentional misuse of medication except as insured under the suicide clause of this policy, use of intoxicants or illegal drugs, or treatment thereof or Accidents related thereto; except as provided under the Legal Substance Abuse Treatment clause.
10. Injuries received as a direct consequence or as a result of the Insured Person having blood content of eighty (80) milligrams or more of alcohol per one hundred (100) milliliters of blood or, in the absence of a specific measurement, in the professional opinion of the attending Physician; except as provided under the Legal Substance Abuse Treatment clause.
11. Any prescription medication classified as a Lifestyle drug.
12. Fertility or infertility treatment and/or drugs related to.
13. Any claim arising from a trip or assignment undertaken outside the Host Country that has been arranged solely for the purpose of securing treatment or therapy unless it has been preapproved by the Insurer.
14. Any Medical Expense incurred relating to a Pre-existing Condition except:
    - Medical Expenses that are medically recognized as Routine Care of the Preexisting Condition but excluding any treatment or surgery which can reasonably be delayed until the Insured Person's expected date of return to their Home Country or Primary Place of Residency outside of Canada without causing irreversible or permanent damage or;
    - Medical Expenses incurred resulting from a change in the Pre-Existing Condition.

In addition to the above, Benefits will not be payable for:

15. Examinations by, or the services of, a Physician if required solely for the use of a third party. Traveling contrary to the medical advice of a Physician or Practitioner or for the purpose of obtaining Medical Treatment or when a terminal prognosis was given to the Insured Person prior to the Coverage Period.
16. Persons age 65 or over; and
17. Any costs incurred during any period for which the appropriate premium has not been paid or while the policy is not in force as to the Insured Person.

Benefits will not be payable for the following:

18. An expectant mother insured by the policy elects to have delivery outside their area of assignment, unless prior approval is received from MSH INTERNATIONAL (CANADA) LTD.

WAR EXCLUSIONS

NUCLEAR, CHEMICAL, BIOLOGICAL TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes any losses, directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement:

“Nuclear, chemical, biological terrorism” shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical agent and/or biological agent during the period of this insurance by any person or group(s) of persons, whether acting along or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

“Chemical agent” shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

“Biological agent” shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

WAR AND TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss if the assured/Insured Person takes an active part therein.

1. War, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; or
2. Any act of terrorism.

   For the purpose of this endorsement an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This endorsement also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to one (1) and/or two (2) above.

If the Underwriters allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance the burden of proving the contrary shall be upon the assured.

In the event any portion of this endorsement is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

YOUR BENEFITS

» MEDICAL

Provided by Certain Lloyd's of London

OVERALL LIFETIME MAXIMUM	LIFETIME MAXIMUM OF $2,000,000
Reimbursement	100% of eligible services
Annual Deductible**	NIL
Doctor's Visit	100% coinsurance
Outpatient Surgery	100% coinsurance
Injections	100% coinsurance
Hospital Fees	100% coinsurance
Emergency Inpatient	100% coinsurance
Prescription Drugs	100% coinsurance, Maximum of 90 – day supply per drug, per policy year
Private Duty Nursing Care	Maximum of $5,000 Lifetime
Annual Physician Visit	After 6 months of continuous coverage, 100% to a maximum of $100 per policy year
Paramedical Services	The services of a registered massage therapist, chiropractor, physiotherapist, osteopath, naturopath, speech therapist, podiatrist or acupuncturist $1,000 per policy year, per insured on outpatient basis
Accidental Dental	$4,000 per accident
Acute Dental	Maximum $600 per emergency for immediate relief of acute dental pain caused by other than a blow to the face
Inpatient Psychiatric Care	Maximum $25,000 Lifetime
Outpatient Psychiatric Care	Maximum $2,500 per policy year
HIV/AIDS/ARC	Maximum $10,000 Lifetime
Trauma Counselling	6 sessions/lifetime if an insured person suffers a covered loss listed in the schedule of losses under the Accidental Death & Dismemberment Benefit, (other than loss of Life) within 90 days from the date of an Accident which occurred during the coverage period, the insured will pay up to 0-6 sessions per lifetime of the insured person for trauma counselling by a registered psychologist when ordered by the attending physician.
Legal Substance Abuse Treatment	Emergency medical services up to a maximum of fifty thousand dollars ($50,000) per Policy Year, per Insured person. Excludes use of illegal drugs/substance, and illegal activity committed by the insured, such as operating a vehicle while impaired.
Maternity	Maximum $25, 000
Well Baby Care	Includes 2 check-ups during first month of life and required immunizations

Eye Exam	One per policy year
Air Evacuation	Not to exceed overall maximum limit
Repatriation	Maximum $15,000 for repatriation back to home country. Maximum $10,000 for burial in country of occurrence.
Pre-Existing Medical Conditions	Covers expenses that are medically recognized as routine care of the Pre-existing conditions but excludes any treatment or surgery which can reasonably be delayed until the Insured Person's. expected date of return to their home country or Primary place of residency outside of Canada without causing irreversible or permanent damage. Covers medical expenses incurred resulting from a change in pre-existing medical condition
Temporary Visit to Home Country	After the later of the commencement of foreign study assignment and the Effective Date, Emergency medical care may be covered for an unforeseen Sickness, Injury, or Accident that occurs during a Temporary Visit to the Insured Persons Home Country subject to meeting the criteria and conditions of the policy definitions of Temporary Visit to Home Country.
Termination Age **Insured Person:** **Dependent Spouse:** **Dependant Child:**	 65 years old 65 years old 19 years old if not continuing in full-time education, or 24 years old if continuing in full-time education.

Notwithstanding the limits stated in the separate sections of this booklet, the overall maximum limit for medical expenses shall not exceed the annual maximum stated above. This maximum is per Insured Person.

All primary Insured Persons, their spouses and eligible Dependent children (as defined by this booklet) are eligible for Medical coverage.

HOSPITAL BENEFITS

When, by reason of Injury or Sickness, an Insured Person is confined to a Hospital, the Insurer will pay the Reasonable and Customary Costs for room and board charges (up to semi-private room accommodation), including the costs relating to Physicians, Surgeons, nursing, operating room, Prescription Drugs, dressings, Diagnostic Services, Medical Appliances, and any other necessary cost made by the Hospital for Inpatient Hospital Services, Day Patient Hospital Services, as well as costs incurred in an intensive care unit.

It is recommended that Insured Persons obtain **pre-authorization** form for scheduled services. **Requests for pre-authorization should be submitted at least 10 days prior to the anticipated service date.**

In the case of an Emergency, it is required that the Insured Person contact MSH Assistance or the Medical Assistance Provider within 72 hours of the Emergency occurring.

OUTPATIENT MEDICAL, SURGICAL AND DIAGNOSTIC SERVICES

When by reason of Injury or Sickness, an Insured Person incurs expenses for any of the following while under the regular care and attendance of a Physician, Surgeon, Physician's Assistant, Nurse Practitioner, Registered Nurse, or Pharmacist – in accordance with each health practitioner's authorized scope of practice the Insurer will pay the Reasonable and Customary Costs incurred for the following:

- **Physician's fees.** All reasonable and customary costs made by a physician, physician's assistants, nurse practitioner, or registered nurse for professional services or medical treatment.
- **Pharmacist.** First consult by a licensed pharmacist will be covered per sickness or injury, per policy year.
- **Prescription medication.** Limited to a 90-day supply of any one type per policy year unless prescribed while a hospital inpatient.
- **Medical equipment and supplies**. (Payable only if required as the result of a covered sickness or injury). Purchase of medical supplies, including dressings and prosthetic appliances. When required as the result of a covered sickness or Injury only, up to $350 for prescription glasses or contact lenses or up to $500 for hearing aids. Rental charges for wheelchairs, crutches, hospital type bid or other appliances, not to exceed the purchase price.
- **Prosthetics** when required as a result of a surgical procedure.
- **Diagnostic, X-Ray, and Laboratory Services**. X-Ray or Laboratory examinations under the attendance or supervision of a Physician, Surgeon, Nurse Practitioner, or Registered Nurse for Diagnostic Services. Laboratory, x-ray, magnetic resonance imaging (MRI), cardiac catheterization, computerised axial tomography (CAT) scans must be provided by or ordered by a Physician, or by a Nurse Practitioner, or Registered Nurse in accordance with their authorized scope of practice.
- **Paramedical Services**. The services of a registered or certified massage therapist, chiropractor, physiotherapist, psychologist, osteopath, naturopath, speech therapist, podiatrist, or acupuncturist up to a maximum of one thousand dollars ($1,000) per profession, per Policy Year, per Insured Person.
- **Private duty nursing care**. Up to a $5,000 lifetime maximum for the services of a registered nurse, Registered nurse assistant or home care worker when ordered by the attending physician.
- **Emergency transport**. The full cost of licensed ambulance service to the nearest hospital when medically necessary. Emergency transfers between hospitals when ordered by the attending physician, including user fee; or, taxi fare to or from a hospital or medical clinic for eligible medical care to a maximum of $100 per illness or injury.
- **Corrective devices**. A device that is required by You on the advice of physician to correct a debilitating physical impairment and without which it would be a physical impossibility for You to continue Your studies or Your teaching responsibilities at the educational institution in which You are enrolled or are teaching. "Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids.

***Note**: the costs of glasses or contact lenses are NOT covered unless required as per the medical equipment and supplies benefit, above*

- **Eye Exams.** Reasonable and customary charges for one non-emergency eye exam performed by a licensed optometrist per 365-day period.
- **Annual physician visit.** When a minimum of 6 months coverage has been purchased, insurer will pay up to $100 for one visit to a general practitioner (physician) during the policy year for a non-emergency exam and associated tests.

Suicide clause. This policy insures medical expenses incurred as a result of attempted suicide subject to the maximums and limitations under this medical benefit subject to the exclusions herein. The "Repatriation or Burial of Deceased" benefit as provided for in paragraph 3 hereunder shall be covered in the event of death by suicide subject to the maximums and limitations under this benefit. The present exception does

not apply to lump sum benefits provided in Accidental death and Dismemberment Benefits subject to Exclusions and Limitations.

Psychiatric care. Up to $25,000 for the services of a psychiatrist while hospitalized as an inpatient due to an emotional disorder. Psychologist, psychiatrist, counselor covered to a combined maximum of $2,500 per policy year per Insured person on outpatient basis.

Pre-Existing medical conditions. Covers expenses that are medically recognized as routine care of the Pre-existing conditions but excludes any treatment or surgery which can reasonably be delayed until the Insured Person's expected date of return to their Home country or Primary place of residency outside of Canada without causing irreversible or permanent damage.

Covers medical expenses incurred resulting from a change in a pre-existing medical condition.

Maternity Services

Maternity coverage up to a combined maximum of $25,000 for pre-natal care, childbirth, post- natal care, and new-born care (up to age 15 days). For new-born coverage past the age of 15 days, an application for dependant coverage must be made within 15 days. Emergency complications due to pregnancy are subject to the Overall Maximum Limit ($2,000,000). Termination of pregnancy is not covered, except in the case of a major, vital complication which presents a clear and significant risk of death to the mother.

Complications relating to maternity care

Complications are defined as any medical condition relating to pregnancy that if not immediately treated will threaten the life of the mother or unborn child.

Well baby care.

Includes a series of regularly scheduled checkups that begin in the first week after birth until the first month of life, subject to a maximum of two visits during this period. Hearing loss assessments and immunizations are also covered under well baby care. Immunizations covered include the first dose of Hepatitis B and the dose for tuberculosis for residents of developing countries.

Emergency Dental Treatment

When an accidental blow to the mouth or face results in injury to an insured person, the insurer will pay for the emergency dental treatment necessary to restore or replace permanently attached artificial teeth or sound natural teeth lost or damaged in an accident up to $4,000 per insured person, per injury.

Emergency repairs to artificial teeth including bridges and denture plates are covered up to a maximum of $500 per insured person, per injury. Dental treatment must be initiated within 90 days following an accident and completed within the policy term. Detailed medical documentation from a physician or dentist must be provided to support an insured person's claim. Expenses incurred as a result of chewing accidents or injury due to placing an object to or in the mouth are not payable.

Acute dental care.

Pays up to $600 reimbursement per emergency for the immediate relief of acute dental pain caused by other than a blow to the face. All treatment must be initiated within 48 hours from the time the emergency began and must be completed no later than 90-days after treatment began assuming coverage is in force during the treatment period dental conditions for which the insured person has previously received treatment or advice are not covered.

HIV/AIDS Coverage

Expenses incurred as a result of a positive HIV, AIDS, or ARC diagnosis, which was diagnosed after coverage commenced, will be based on standard terms and conditions of the policy and covered to a lifetime maximum of $10,000.

Legal Substance Abuse Treatment

Emergency medical services up to a maximum of fifty thousand dollars ($50,000) per Policy Year, per Insured person. Excludes use of illegal drugs/substances, and illegal activity committed by the insured, such as operating a vehicle while impaired.

Your insurance also covers:

Mountaineering, scuba diving, rock or precipice climbing. This policy covers medical expenses incurred as a result of mountaineering and scuba diving to a depth of 15 meters, and rock or precipice climbing up to 15 meters in height, subject to the maximums and limitations under this medical benefit.

Trauma counselling. If a insured person suffers a covered loss listed in the schedule of losses under the Accidental Death & Dismemberment benefit, (other than loss of life) within 90 days from the date of an Accident which occurred during the coverage period, the insurer will pay up to six sessions per lifetime of the insured person for trauma counselling by a registered psychologist when ordered by the attending physician.

Returning insured benefit. Coverage for a maximum of 90 consecutive days is available to insured person's permanently returning to their home country provided premium has been paid for this period.

The following Benefits are covered with the prior approval from Your Medical Assistance Provider. The maximum amount payable for the following Transportation Benefits cannot exceed the Overall Maximum Limit.

Air Evacuation

The cost of transporting You to the nearest Hospital or to a Hospital in Your Home Country, if Medically Necessary, either:

a) as a stretcher fare in a regular flight, including economy return fares for qualified medical attendants (not a relative) and their associated fees and expenses; or

b) an appropriately equipped air ambulance, including associated fees and expenses for a qualified crew. Land ambulance costs at each end of the flight or connecting flights are included. The attending Physician must certify that the Insured Person is medically fit for the type of transfer selected.

Repatriation of Mortal Remains or Local Burial

If death occurs during the coverage period as result of a covered injury or sickness, the insurer will pay either.

a) Up to $12,500 towards the reasonable and customary costs of the preparation and return of the insured person’s remains to the insured person’s home country in a standard transportation container, or

b) Up to $10,000 for the cost of preparing the remains cremations or burial, and a burial plot in the location where death occurs. The cost of a coffin, urn headstone or funeral are excluded.

Costs of Returning Home due to Family Emergency.

If the Insured Person must unexpectedly return Home due to the fact that an Immediate Family Member who is not traveling with the Insured Person has died, or is hospitalized for a serious Sickness, the Insurer will pay up to a lifetime maximum of $2,500 towards the cost of round-trip transportation based on the lowest available fare for the most direct route to the location nearest the institution where the Immediate Family Member is being held. The Insurer will also pay up to lifetime maximum of $1,000 for commercial accommodation and meals for the Insured Person. This Return Home Benefit must occur within the Coverage Period.

Family Transportation and Subsistence Allowance.

If You have no family members within 500 kilometers of Your location while You are outside Your Home Country and You are Hospitalized, and Your Hospitalization is expected to last a minimum of 7 days or in the event of the death of the Insured Person. The Insurer will pay up to a combined lifetime maximum of $7,500 towards the cost of round-trip transportation based on the lowest available fare for the most direct route for two (2) persons nominated by You to travel to Your bedside, as well as for commercial accommodation and meals for a maximum period of 7 days for these two (2) persons. The attending

Physician must certify that the situation is serious enough to warrant the visit. Submit all bills and receipts to the Claim Administrator.

Return Home
If, in the event of Emergency Sickness or Injury of the Insured Person which necessitates the return home of the Insured Person for immediate medical attention, the Insurer will reimburse the actual extra cost of a one-way economy airfare by the most direct route for the Insured Person to return to Insured Person's Home Country, up to a lifetime maximum of $5,000.

Please refer to the Policy Exclusions section for exclusions and limitations

» ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Provided by Certain Lloyd's of London.

Benefit Schedule	Flat amount of $50,000
Termination Age	65

The principal sum is a flat amount of $50,000.

ELIGIBILITY

All primary Insured Persons are eligible for Accidental Death & Dismemberment coverage. Coverage is not available for spouses or Dependent children of the primary Insured Person.

AGGREGATE LIMIT OF LIABILITY: $10,000,000

The Insurer shall not be liable for any amount in excess of the above stated aggregate limit of liability.

If the aggregate amount of all indemnities otherwise payable by reason of coverage provided under this policy exceeds such aggregate limit of liability, the Insurer shall not be liable as respects to each Insured Person for a greater proportion of the indemnity otherwise payable than the aggregate limit of liability bears to the aggregate amount of all such indemnities.

COVERAGE

Accidental Death, Dismemberment, Loss of Sight and Paralysis.

If such injuries shall result in any one of the following specific losses within one year from the date of Accident, the Insurer will pay the Benefit specified as applicable thereto, based upon the principal sum stated in the Insured Person's application provided, however, that not more than one (the largest) of such Benefits shall be paid with respect to all injuries resulting from one Accident.

Life	100%
One hand and one foot	100%
One hand or one foot and the sight of one eye	100%
Both hands or both feet or the sight of both eyes	100%
Speech and hearing in both ears	100%
Sight of one eye	66 2/3%
Hearing in both ears	66 2/3%
Speech	66 2/3%
Thumb and index finger of same hand	33 1/3%
Hearing in one ear	25%
Four fingers of the same hand	33 1/3%

All toes of the same foot	12 1/2%
Both hands or both feet	100%
Both arms or both legs	100%
One arm or one leg	75%
One hand or one foot	66 2/3%
Quadriplegia	100%
Paraplegia	100%
Hemiplegia	100%

Cumulated AD & D benefits shall never exceed 100% of the lump sum. “Loss” shall mean:

- With respect to hand or foot, the actual severance through or above the wrist or ankle joint;
- With respect to arm or leg, the actual severance through or above the elbow or knee joint;
- With respect to eye, the total and irrecoverable loss of sight;
- With respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree;
- With respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid of device;
- With respect to thumb and index finger, the actual severance through or above the first phalange;
- With respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand;
- With regard to toes, the actual severance of both phalanges of all toes of the same foot.

“Loss” as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

“Loss of use” shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the Insurer to be permanent.

EXPOSURE AND DISAPPEARANCE

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the Benefits afforded an Insured Person.

If the body of an Insured Person has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which the Insured Person was riding at the time of the Accident, it shall be presumed subject to all other conditions of the policy, that the Insured Person suffered loss of life resulting from bodily injuries sustained in the Accident and covered under this policy.

PROVISIONS

Notice of Claim: Written notice of claim must be given to the Insurer within 30 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice by or on behalf of the claimant to the Insurers or to any authorized agent of the Insurer, with information sufficient to identify the Insured Person, shall be deemed notice to the Insurer.

Claim Forms: The Insurers, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time of Payment of Claim: Indemnities payable under this policy shall be paid by the Insurer within 60 days after it has received proof of claim.

Payment of Claims: Indemnity for accidental loss of life will be payable to the beneficiary of record in a lump sum. The lump sum payment shall be paid by the Insurer within 60 days after it has received proof of claim.

If, at the death of the Insured Person, there is no surviving beneficiary, the accidental loss of life indemnity shall be payable in one sum to the estate of the Insured Person.

All other indemnities will be payable to the Insured Person.

Physical Examinations and Autopsy: The Insurers at its own expense shall have the right and opportunity to examine the body of any Insured Person whose Injury is the basis of claim when and as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Designation or Change of Beneficiary: Subject to any statutory restrictions, an eligible Insured Person may designate a beneficiary to receive death Benefits payable under this policy or may change any beneficiary already appointed, by filing written notice. No designation or change of beneficiary under the policy shall be binding upon the Insurer until the original or a duplicate thereof is received by the designated custodian or beneficiary records. No assignment of interest shall be binding upon the Insurer until the original or a copy thereof is received by the Insurer. The Insurer assumes no responsibility for the validity or legal sufficiency of such designation or change of beneficiary assignment.

Conformity with Provincial Statutes: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the province in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such province.

Workers' Compensation Laws: This policy is not in lieu of and does not affect any requirements for coverage under any Workers' Compensation Law.

AD&D EXCLUSIONS AND LIMITATIONS

1. AD&D coverage is not insured in the event of suicide.

Please refer to the General Exclusions section for additional exclusions and limitations.

MEDICAL EVACUATION & REPATRIATION

MSH Assistance provides you 24/7 Worldwide Emergency Coverage. In the event of Emergency Hospitalization please call:

+1 800 808 2694 (from Canada and United States)
+1 (403) 538 2364 (Collect to Canada from anywhere else in the world)
mshassistance@mshassistance.com

24 hours a day, 7 days a week, 365 days a year

In order to assist you in an Emergency situation, MSH Assistance will require the following information when you contact them:

- Name of caller, telephone number and relationship to the patient
- Name, age, sex, and location of the patient
- The patient's iMED **Member Policy Number** and **Group Policy Number** (indicated on the iMED health insurance ID card)
- Nature of medical problem
- Name and contacts for the medical facility and the attending medical personnel
- How and when the next communication will take place

In the event you are admitted to a hospital MSH Assistance must be notified immediately. They will take the appropriate action to assist you and monitor your care until the situation is resolved.

YOUR PROCEDURES WITH MSH

PRECERTIFICATION

To confirm that expenses for specific services to be rendered at a future date will be covered, you may request a precertification of expenses from MSH International (Canada) Ltd.

To obtain a precertification:

- Contact the MSH Precertification Department by email at: mshassistance@mshassistance.com, and/or call MSH Assistance 24/7 at **1-800-808-2694** or at **+1 (403) 538-2364**
- Upon receipt of information required to pre-certify specific services and relates expenses, MSH Assistance will issue a precertification letter that details the coverage available for the specific services indicated, including any maximums or limitations.
- **Requests for precertification should be submitted at least 10 days prior to the anticipated service date.** Precertification requests will be processed within 3 to 5 business days.
- **In the case of an emergency hospitalization you (or someone on your behalf) must contact MSH Assistance within 72 hours of hospital admission, or as soon as reasonably possible.**

Pre-certification is **required** in all cases of hospitalization, outpatient surgery, and medical transportation (except for local emergency transportation). Plan payments may be reduced to 20% of normal payment if the Insured Person does not follow the following instructions or if a pre-certification agreement is not obtained from MSH Assistance. The Insured Person is required to contact the MSH Assistance's pre-certification counselor one or two weeks before entering a hospital for non-emergency treatment or undergoing outpatient surgery.

Please note: When there is little known about the cause of manifesting symptoms, or when the medical necessity of a treatment is not yet verified by a physician, it may sometimes not be possible to obtain pre-authorization of medical expenses until after an initial medical consultation, when a medical diagnosis or medical recommendation or requisition is made.

DIRECT BILLING

A direct billing arrangement allows a treating facility to send the invoice directly to MSH International (Canada) Ltd. for payment. This can prevent you from having to pay medical expenses out-of-pocket. While MSH International (Canada) Ltd. is willing to work with any medical facility to make these arrangements, the facility must also be in agreement and be willing to accept payment directly from our offices. A list of direct billing medical providers on or close to University of British Columbia campuses is available at the iMED plan website **www.imed.david-cummings.com**

To arrange for a direct billing relationship:

- Prior to accessing services, the Insured Person may contact the MSH Assistance to inquire about facilities within their area with whom an agreement is already in place;
- If you are in a location for which you have received a Direct Billing Card, please present this card to the participating medical network facility;
- If you are covered within the United States and are seeking treatment in the United States, please contact MSH Assistance for a referral to physicians or medical facilities in your area, and for pre-authorization of medical services.
- You may also choose to contact a facility directly prior to treatment to confirm whether the facility is willing to bill expenses directly to MSH International (Canada) Ltd. Upon confirmation that a clinic is willing to bill direct to MSH, the facility contact information must be provided to MSH Assistance by you or the facility. MSH will issue a letter directly to the facility confirming that subject to the terms and conditions of your insurance policy, we will pay eligible expenses to the facility upon receipt of the invoices and related health records to support the claim.

HOW TO CLAIM?

Help us provide the best possible claims service by making sure that your claim form is fully and accurately completed, and by providing all necessary supporting documents. You may download the iMED medical claim form from the iMED website listed on your iMED health insurance ID card. Please refer to claim documentation requirements in the *Submission of Claims* section below.

Claims must be submitted within the required time after the expense is incurred. Since mail delays can be extensive, or affected by postal service disruption, all claims should be submitted as quickly as possible to:

MSH INTERNATIONAL – CLAIMS DEPARTMENT
150 King Street West, Suite 602
PO BOX 75, Toronto ON
Canada M5H 1J9 Canada

Tel. +1 800 808 2694 (Toll Free from Canada and United States)
Tel. +1 (403) 538 2364 (Call Collect to Canada from anywhere else in the world)

mshclaims@mshassistance.com

TIME LIMITS FOR SUBMITTING CLAIMS

It is important to note the time requirements for submitting claims. The following summary outlines these requirements.

Written proof of loss for **Medical Claims** is required by the earlier of the following deadlines:

No later than 365 days from beginning of medical treatment
or
No later than 120 days after the Insured Person's date of termination (or **180** days after the Insured Person's date of termination if the billing is made direct from the service provider).

All claims must be submitted no later than 365 days from the beginning of the medical treatment, or 120 days after the Insured Persons date of termination (or 180 days after the Inured Persons date of termination if the billing is being sent direct from the provider) whichever is earlier.

Time limits for submitting **Accident Death & Dismemberment (AD&D)** Claims*:

Written Notice of Claim	30 days after the occurrence or commencement of any loss
Written Proof of Loss	90 days after the date of such loss

*Refer to Provisions under the AD&D Benefit for additional details.

MSH International (Canada) Ltd recommends that you **retain a copy of the claim form and all documents relating to your claim for your records.**

RIGHTS OF EXAMINATION

As a condition precedent to recovery of insurance moneys under this contract:

- The claimant shall afford to the insurer an opportunity to examine them when and so often as it reasonably requires while the claim hereunder is pending;
- And in the case of death of the Insured Person, the Insurer may require an autopsy subject to any law of the applicable jurisdiction to autopsies.

COORDINATION OF BENEFITS

If an Insured Person and/or his eligible dependants are covered by a government program or another health policy (individual, employer, educational institution, professional association, etc.), the benefits of both plans will be coordinated in order that the combined payments do not exceed the actual covered expenses.

The general rule is that one policy pays first and the second policy pays the remaining eligible expenses up to the limits in the second plan. The Insurer of the second policy should receive an original copy of the first policy's reimbursement statement and photocopies of all relevant bills.

The following list identifies which policy should receive the original bills and act as the "First Policy" for:

All Insured Persons

- Government programs (Social Security, Medicare, etc.);
- Non-health insurance (automobile, homeowner's, liability, etc.).

SUBMISSION OF CLAIMS

HEALTH / MEDICAL CLAIMS

All documentation relating to the claim including the claim form and accounts must be provided. Copies of original documents will be accepted. The original receipts must be retained by the Insured Member for a period of 24 months from the date the claim was incurred during which time MSH INTERNATIONAL (CANADA) LTD. may request these documents to validate any claim at any time. In the event the original copy cannot be produced, the Insured Member will be responsible for any claim payments made in regard to that receipt.

*Invoices received directly from a provider will be considered to be an original document including but not limited to facsimiles, scans, PDF documents, direct portal submissions or digital copies.)

Hospital

Submit a Medical Claim Form plus a detailed receipt signed by the hospital showing:

- Patient's name and date of birth.
- Name and address of hospital (as well as phone/fax number and email, if available).
- Date of service and/or length of stay.
- Type of accommodation (private or semi-private room).
- Daily room and board charge.
- Procedure/special charges by hospital (e.g., drugs, x-rays, surgical procedure, etc.).
- Physician's charges (if any) and currency.
- Description of sickness or injury/diagnosis.
- Amount paid by Insured Person and/or amount to be paid to provider (please indicate currency).

Medical treatment

Submit a Medical Claim Form. Applicable sections of the form are to be completed by the insured. If the receipt does not include the following information, please have your doctor complete a Physician's Statement.

- Patient's name and date of birth.
- Name and address of facility (as well as phone/fax number and email, if available).
- Date of service.
- Description of sickness or injury/diagnosis.
- Type of procedure rendered.
- Number of services or visits made.
- Amount paid by Insured Person and/or amount to be paid to provider (please indicate currency).
- Have the doctor PRINT his name and address, then date and sign the form.
- Attach original receipt from the doctor.

Prescription drugs

Submit a Medical Claim Form. Applicable sections of the form are to be completed by the Insured. The following information is required:

- Patient's name and date of birth.
- Name of drug or medication.
- Number of days of supply.
- A dated receipt.
- Amount paid by Insured Person and/or amount to be paid to provider (please indicate currency).
- The form must then be signed by you and the total amount of the charges shown.

Medical Emergency Evacuation

If medical treatment is required for an emergency outside North America, the insured, or someone acting on their behalf, **MUST call the toll-free (or collect) number provided on the identification card.** Immediate help is arranged and continued monitoring is provided during the emergency. MSH Assistance representatives look after hospital admission, referral to doctors, drugs, ambulance, family transportation, airfares, attendant care, return and burial if death occurs.

However, receipts should be kept for emergency services that cost $200 or less, and for expenses that exceed the specific allowances described in the evacuation policy. These should be **submitted together with an authorized Medical Claim Form when the insured returns home.**

Emergency assistance must be arranged by calling MSH Assistance. Otherwise, Emergency Evacuation (transport) expenses will not be eligible for reimbursement.

AD&D

Notify the MSH Administrator as quickly as possible. We will provide the appropriate forms.

METHOD OF REIMBURSEMENT

When sending in your claim, please ensure that your return address and contact information are clearly shown so we can contact you when necessary.

ALL CLAIMS RECEIVED FOR REIMBURSEMENT ARE CONVERTED TO THE CURRENCY OF THE CONTRACT.

The exchange rate utilized for calculation purposes is the rate published by The United Nations. The exchange rate calculation is based on the rate available upon the date the service was rendered.

Claim reimbursement can be made using one of the following methods as selected at the time of claim or as information has been provided on the enrollment form.

Benefit Cheque

A claim payment cheque will be mailed to the address provided on the claim form.
All cheques will be issued in the currency selected, subject to availability.

Wire Transfer

You may request that claims payment be wired into your account anywhere in the world. MSH International (Canada) Ltd. will cover the costs of sending the wire payment, however, please note, it is common for receiving banks to charge you for the cost of receiving the wire transfer. This amount will be deducted from the claim payment and is the responsibility of the account holder.

DEFINITIONS

Any word explained in the Definitions section herein have the same meaning throughout this document.

Accident: Any sudden and unforeseen event occurring during the policy term, resulting in bodily Injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control. For the purpose of the AD&D Benefit insured under this policy, please note the accident must occur during the policy term.

Benefits: Any covered expenses/services that the Insurer will pay under this policy.

Benefit maximum: The amount stated as the maximum payable for any particular benefit per policy year, unless otherwise stated.

Complications relating to maternity care: Complications are defined as any medical condition relating to pregnancy that if not immediately treated will threaten the life of the mother or unborn child.

Corrective device: A device that is required by the Insured on the advice of a physician to correct a debilitating physical impairment and without which it would be a physical impossibility for the Insured to continue her/his studies or his/her teaching responsibilities at the educational institution in which the insured is enrolled or is teaching.

"Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids.

Couple Coverage: Coverage that includes the primary Insured person and an eligible spouse or eligible dependent child, as defined by this policy.

Coverage Period: The period of time during which You are insured for the Benefits provided by this policy, starting from 12:00 a.m. on the Effective Date until 11:59 p.m. on the latest of the date (a) specified as the Termination Date on the enrollment form; or (b) of termination of any extension of this policy. The maximum Coverage Period including extensions is 365 consecutive days at any one time. Coverage for a maximum of 90 consecutive days is available to Insured Persons permanently returning to their Home Country or Primary Place of Residency provided premium has been paid for this term.

Day Patient: A patient who occupies a hospital bed or is charged for a hospital bed.

Deductible: The dollar amount for which the insured person is liable before any remaining eligible expenses are reimbursed under this policy.

Dentist or Dental Surgeon: A practitioner who holds a Doctor of Dentistry degree and is legally registered and licensed to practice dentistry in a country where services within the scope of their license are provided.

Dependant:

- The spouse or common law spouse (including same sex) of a primary Insured Person (but excluding those legally separated), and under the age of sixty-five (65).
- Unmarried children, step-children, foster children and legally adopted children, who are dependent on the primary Insured Person for support, provided that such children are not less than 15 days old, and not more than eighteen 18 years old (or under the age of twenty-four (24) years old provided it can be proven that the child is continuing in full-time education).
- Unmarried children, step-children, foster children and legally adopted children, who are dependent on the primary Insured Person for support due to physical or mental disability.

Diagnostic Services: Laboratory tests and x-ray services, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions.

Disability: The inability to perform the principal duties of any occupation in relation to the Insured Person's education, skills, training and experience.

Effective date: Means either

a) The date the Eligible insured person arrives in the location of foreign study or assignment. In this case coverage is automatically provided to a maximum of 10 days while traveling to location of foreign study or assignment from her/his home country or primary place of residency: or

b) A later date as communicated by the Plan administrator.

Elective Medical Treatment: means any medical treatment, surgery, or procedure which:

a) Is not necessitated by a pathological or traumatic change in the function or structure in any part of the body, and/or

b) could be reasonably delayed until the Insured Person's expected date of return to their Home Country or Primary Place of Residency outside of Canada without causing irreversible or permanent damage.

c) any treatment that is not Medically Necessary as per the definition of the policy

Emergency: A sudden and unexpected medical condition or Injury that requires immediate medical treatment. The condition or injury must have manifested itself while this policy is in force as to the Insured Person.

Expatriate: A person who leaves his/her home country to reside in a foreign country for which he/she does not hold a valid passport.

Home Country: The country for which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be taken to mean the country that the Insured Person has declared on the application form. Where a family is to be covered by the policy there will be deemed to be one Home Country for that family, which will be the Home Country declared on the application form.

Hospital: Any medical or surgical institution which is legally licensed in the country in which it is located and whose main activities are not those of a rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident Physician.

Hospital Services: Costs for accommodation, nursing, operating theatres, drugs, dressings, Diagnostic Services or any other necessary costs made by the Hospital for medical treatment.

Host Country: The country, outside of the Insured Person's Home Country, for which the Insured Person is travelling to, as declared by the policyholder.

Immediate Family Member: Refers to spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, brother-in-law, sister-in-law, father-in-law, mother-in-law, grandson, granddaughter, grandfather or grandmother of the Insured Person.

Injury: Any harm to the body caused by an Accident resulting, directly and independently of all other causes, in the Insured Person incurring Medical Expenses.

Inpatient: A patient who occupies a Hospital bed for more than twenty-four (24) hours for medical treatment and for which admission was recommended by a Physician or Surgeon.

Insured Person/You/Your: An eligible person as defined in the eligibility section of this policy.

Insurer: Certain Lloyd's Underwriters.

Lifestyle Drugs: Pharmaceutical products that depict improvements to a person's way of life, style of living, function or appearance. Including but not limited to baldness, aging, acne, erectile dysfunction, obesity, and smoking cessation.

Maternity Care: Refers to the Medically Necessary expenses associated with pregnancy and childbirth.

Medical Appliances: Minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, orthotics and the temporary rental of a wheelchair when prescribed by a Physician or Surgeon.

Medical Assistance Provider: MSH Assistance.

Medical Expenses: Those medical and related expenses for which coverage is provided under the Health Care Benefits section of this policy which are necessarily incurred as a result of Injury or Sickness while coverage is in force under this policy as to the Insured Person.

Medically Necessary: Those services or supplies which are provided to the insured person that are required to identify or treat her/his sickness or Injury and that are necessary for the relief of acute pain or suffering, or to identify or treat her/his sickness or injury; or with respect to hospital services, those which cannot safely be provided to the insured person as an outpatient.

Member of the Subscribing University: Means a Primary insured person (international student) who is deemed a registered student with the subscribing university as of the Insured Person's policy effective date.

Mountaineering: Means the ascent or descent of a mountain requiring the use of specialized equipment, including crampons, pick-axes, anchors, bolts, carabineers and lead-rope or top-rope anchoring equipment.

MSH INTERNATIONAL (CANADA) LTD: The third-party administrator and claims administrator appointed by the Insurer.

Newborn Child Care: The Medically Necessary expenses associated with the care and treatment of a newborn child while in Hospital immediately following birth and any Medically Necessary expenses incurred up to the guaranteed period of coverage elected under Maternity Care.

Nurse Practitioner (NP)*: Nurse practitioners are registered nurses with experience and advanced nursing education at least the graduate level. Nurse practitioners are licensed to autonomously diagnose, treat, and manage acute and chronic physical and mental illnesses.

**The Scope of practice for Nurse Practitioners in British Columbia is set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act.*

Outpatient: An Insured Person who receives treatment, including Diagnostic Services at a Hospital, or other medical institution, or at a Physician's office; where the Insured Person is not admitted or confined to a Hospital bed as an Inpatient or Day Patient.

Overall Maximum Limit: The total aggregate annual limit that may be claimed by an Insured Person. Such limit is indicated in the wording of this policy.

Pharmacist: Dispense prescription medications and provide information to patients about the drugs and their use.

Physician's Assistant (PA): A PA is a medical professional who works as part of a team with a medical doctor. A PA is a graduate of an accredited PA educational program who is nationally certified and licensed to practice medicine with the supervision of a physician.

Physician or Surgeon: A legally licensed medical practitioner recognized by the law of the country where treatment is provided and who, in rendering such treatment, is practicing within the scope of his/her licensing and training. A physician or surgeon must not be the insured person or an immediate family member of an insured person.

Policy year: the 12-month period beginning on the date the primary insured person's coverage under the policy commences. Subsequent policy years commence on the anniversary of that date.

Pre-existing condition: a Sickness or Injury which occurs prior to the effective date of coverage under this policy.

Prescription Drugs: Drugs, medicines, serums and vaccines which must, by federal law or regulation in the country where incurred, be dispensed only pursuant to a prescription from a licensed Physician or

Dentist. For geographical areas where there are no regulatory laws for such substances, eligibility will be determined by Canadian standards as defined by the Canadian Food and Drugs Act and Regulations.

Primary place of residency: The location where the insured person maintains a permanent residence that is not located in the home country.

Prosthetic: A device, external or implanted, that substitutes for, or supplements a missing or defective part of the body.

Reasonable and Customary Costs: Costs incurred for approved, eligible treatment or supplies that do not exceed the standard costs of other providers of similar standing in the same region, for the same treatment of a similar Sickness or Injury.

Registered nurse (RN)*: is a nursing professional that directly cares for individuals, families, groups and communities. A Registered Nurse will coordinate with a physician and other healthcare providers.

**The Scope of practice for Nurse Practitioners in British Columbia is set out in the Nurses (Registered) and Nurse Practitioners Regulation under the Health Professions Act.*

Routine Care: Designated for patients who require a physician visit for a medical service, including diagnostic services and medication, that is not considered urgent at the time of the initial visit. Routine care does not include annual physician visits.

Sickness: Any illness or disease contracted by an Insured Person which causes the Insured Person to incur Medical Expenses.

Temporary Visit to Home Country: Means a temporary visit or visits to one's Home Country that occurs during the Coverage Period, after the Insured has commenced residing in the country of foreign study assignment. Coverage during a Temporary Visit to Home Country is restricted to Emergency medical care for an unforeseen sickness, injury or accident. Routine Care for a pre-existing medical Condition is not covered during a Temporary Visit to Home Country. Unless pre-approved in writing from the Insurer, or its authorized representative, coverage during a Temporary Visit to Home Country cannot exceed the **cumulative** maximum of 15 days during the Coverage Period.

Terminal prognosis: Means you have a condition that is cause for the physician to estimate that you have less than 6 months to live.

Well Baby Care: The customary Health Care services provided to a healthy newborn that are determined to be Medically Necessary, even though they are not provided as a result of illness, Injury or congenital defect. This includes a series of regularly scheduled check-ups, hearing loss assessments and immunizations. Please refer to the Medical Benefit for coverage and limitations.

Worldwide: As applicable to the Zone of Coverage, Worldwide comprises all countries throughout the world.

PRIVACY GUIDELINES

At MSH INTERNATIONAL (CANADA) LTD., we recognize and respect every individual's right to privacy. When you apply for coverage or Benefits, we establish a confidential file of personal information.

We use the information to administer the Benefit plan. This includes many tasks, such as:

- Determining an Insured Person's eligibility for coverage under the plan
- Enrolling Insured Person's for coverage
- Assessing an Insured Person's claims and providing them with payment
- Managing an Insured Person's claims
- Verifying and auditing eligibility and claims
- Underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Providing the applicable Regulatory Forms and Tax Receipts, upon request

We limit access to information in the Insured Person's file to MSH INTERNATIONAL (CANADA) LTD. staff or persons authorized by MSH INTERNATIONAL (CANADA) LTD. who require it to perform their duties, to persons to whom the Insured Person has granted access, and to persons authorized by law. MSH INTERNATIONAL (CANADA) LTD., the Insured Person's health care provider, other insurance and reinsurance companies, and the plan administrator of the policyholder may also exchange information when the information is needed to administer the Benefit plan.

For questions or concerns regarding the collection, use, disclosure or storage of personal information, **please contact the Privacy Officer** by mail or email. Concerns will be addressed within 30 days.

MSH INTERNATIONAL (CANADA) LTD
c/o Privacy Officer
2900, 605 -5th Avenue SW
Calgary, Alberta T2P 3H5 Canada
Email: privacyofficer@americas.msh-intl.com

This booklet is not a legal document. If you wish to know the precise terms of your legal entitlements to any of the Benefits described, reference should be made to the actual insurance policy and supplements, which govern and stipulate the Benefits to which you are entitled under those particular documents, together with the terms and conditions subject to which you are entitled to receive those Benefits.

The policyholder reserves the right, subject to the terms of the insurance policy and the applicable statutory regulations, to amend, suspend or discontinue, in whole or in part, any Benefit described in this document. Participants will be sent a notice advising them of the action taken and its effective date.

ORIENTATION TO GETTING HEALTH CARE WITH IMED INSURANCE

Insured plan members may seek medical care at any licensed medical clinic or hospital. Eligible medical expenses can either be claimed to MSH by you, the Insured Person, or directly by the medical facility.

Important Tips!

1. In Canada seeking treatment at a hospital is reserved for medical **emergencies** which cannot be safely treated at an out-patient doctor clinic or in a virtual doctor consultation, or that due to medical urgency cannot wait for the soonest-available doctor consultation at a non-hospital facility. Wait times at hospital emergency rooms can last many hours, so people with minor ailments are strongly advised to seek medical attention at a non-hospital facility.
2. If you need care at a hospital, always show your **iMED health insurance card** and a copy of your **study permit** (if you have one) when you are being admitted. Study Permit holders should qualify for lower hospital rates.
3. When you register as a patient at any clinic, use your name as it appears on your iMED health insurance card. Otherwise, there could be a delay in verifying your coverage and in processing your iMED insurance claim
4. Before leaving a hospital or medical clinic**,** ask the doctor or the clinic staff for a copy of your health records for that visit. While you would have the right to request a copy of your health records after leaving a medical facility, obtaining health records after discharge from a hospital can take six weeks or longer.

This step will prevent delay in the processing of your claim – especially if your are at a facility that will not bill your patient fees direct to MSH - because MSH needs health records that indicate the condition or symptoms that prompted your need for medical services and your diagnosis; that confidential information is often not included on medical invoices.

iMED Direct Billing Network

For your convenience, certain doctor clinics, hospital emergency departments, and pharmacies are set up to bill eligible medical expenses **directly to MSH**. To access a direct billing facility, you will need to show your iMED Card, and a piece of photo identification. You may view the list of medical facilities in the **iMED Direct Billing Network** at the iMED website indicated on the front of your iMED health insurance card.

If you are not near a medical facility in the iMED Direct Billing Network, call **MSH Assistance** regarding your need of medical attention and your location, and MSH may be able to refer you to a local medical clinic willing to bill MSH directly, based on a pre-authorization of medical services.

Free virtual doctor consultation with Maple.ca

While your iMED policy is active, you may sign up for a Maple.ca account for free with your iMED Member Policy Number. Once signed up you can conveniently connect 24/7 with Canadian-licensed doctors and nurse practitioners for online medical care from your phone, tablet, or computer.

Common medical issues treated over virtual consultation include:
cold/flu, cough/sore throat, sinus infection, upset stomach, urinary tract infection, skin problems, allergies.

How to get free virtual doctor consultation using the Maple app:

Step 1 – Create a Maple account at getmaple.ca/msh
Visit getmaple.ca/msh to register for a free Maple account using your **iMED Member Policy Number** (on your iMED Card). During the registration process you will create a login password.
Note: your ability to use the Maple app for free will be restricted to your iMED coverage period.

Step 2 – Login to your account at app.getmaple.ca/login
After registering visit app.getmaple.ca/login to login with the email and password you set up.

Step 3 – Click "Get Care" on your Maple app dashboard
Follow the in-app prompts to book a doctor consultation.

Step 4 – Your Doctor Consultation
Discuss your symptoms with the Maple doctor over secure messaging, audio, or video chat. If you receive a prescription it can be sent to your choice of local pharmacy. As needed Maple doctors can order diagnostic tests, and provide a specialist referral. Your medical records will be accessible to you within the Maple app.

For more details, refer to the *Virtual Care* page of the iMED website.

What to expect at different types of medical facilities:

At an Out-Patient medical clinic, expect to be required to pay up-front for consultation with a doctor (or paramedical practitioner) **unless** you visit a clinic in the iMED Direct Billing Network. If you pay up front, **ask for a copy of your health record for that visit** as it will be needed to make a claim.

At a Hospital Emergency Department, your patient invoice would normally be mailed in hard copy to you after discharge, with instructions on how to pay your invoice. **Before leaving an Emergency Room** ask for a copy of your health records as they will be required to make a claim. If you are treated at a Hospital Emergency Room in the iMED Direct Billing Network then your patient invoice and health records should get submitted directly to MSH on your behalf.

If admitted as a Hospital In-Patient, you (or someone on your behalf) **must** contact MSH Assistance immediately, or within 72 hours. **Call 1 (800) 808-2694.**
If you cannot call, write to mshassistance@mshassistance.com

MSH will do their best to coordinate direct billing from the hospital even if the hospital is not in the iMED Direct Billing Network. However, please note that some hospitals will only issue invoices the patient's address. If your email or mailing address changes you must update the hospital billing department.

FREQUENTY ASKED QUESTIONS

FAQ - COVERAGE

1. **Are pre-existing medical conditions covered?**

Yes, subject to the terms, conditions, benefit limits and exclusions, iMED includes coverage of pre-existing medical conditions for both medically necessary Emergency/Urgent treatment and Routine Care. Please refer to the policy details above. For pre-authorization of a specific type or scenario of medical expense relating to a pre-existing condition, contact **MSH Assistance**.

2. **Am I covered in my Home Country?**

Coverage for a maximum of 90 consecutive days is available to Insured's **permanently returning** to their Home Country or Primary Place of Residency provided premium has been paid for this term.

Coverage during a temporary visit home country:

After the later of the commencement of foreign study assignment and the Effective Date, **Emergency medical care** may be covered for an unforeseen Sickness, Injury, or Accident that occurs during a **Temporary Visit to the Insured Person's Home Country**, subject to meeting the criteria and conditions of the policy definition of Temporary Visit to Home Country.

FAQ - CLAIMS

1. **Where can I get the iMED Medical Claim Form?**

You can download a claim form from the iMED website. Use the web address indicated on the front of your iMED health insurance ID card. Alternatively, you can call or write to MSH Assistance to request of the UBC-iMED medical claim form. Be sure to mention the group policy number on your iMED card.

2. **What is the deadline for submitting medical claims?**

Medical claims must be submitted to MSH by the earlier of the following dates:

No later than 365 days from the date the claimed medical service was received
or
No later than 120 days after the Insured Person's date of termination (or 180 days after the Insured Person's date of termination if the billing is made direct from the service provider).

3. **Where are my claims processed and paid?**

All claims are processed at MSH INTERNATIONAL's claim center located at:

NORTH AND SOUTH AMERICA 150 King Street West, Suite 602 PO BOX 75, Toronto ON M5H 1J9 Canada msh**claims**@mshassistance.com **Fax.** +1 (416) 730-1878	**Contact MSH for Claims Inquiries**: For help over the phone for making a claim, and to check on the status of a claim, call **MSH Assistance** and follow the prompt to reach the **Claims Department**.

4. **How do I make a claim?**

Claims should be submitted as per the guidelines outlined on pages **19 – 22** of this booklet**.**

5. **Will MSH provide direct reimbursement to a hospital or medical provider?**

On approval of the hospital or medical provider, direct payment to the billing medical provider can be made. You will be required to provide the hospital or provider's name, location, telephone, and fax number so that arrangements can be made for direct payment as allowed by provider. You or your medical service provider may request pre–authorization of medical treatment by contacting **MSH Assistance**.

MSH Assistance (open 24/7)
+1 (800) 808 2694 *(Toll Free from Canada and United States)*
+1 (403) 538 2364 *(Call Collect to Canada from anywhere else in the world)*
mshassistance@mshassistance.com

In order to verify your coverage and to assist you in an Emergency situation, MSH Assistance will need the following information when you contact them:

- Your full name as it appears on your iMED health insurance ID card
- Your Date of Birth
- Your present location, and telephone number you can be reached at
- Your iMED **Member Policy Number** and **Group Policy Number** (indicated on the iMED health insurance ID card)
- Nature of medical problem
- If you call from a medical facility, you will need to provide name and contacts for the medical facility and attending medical personnel
- If someone calls MSH on your behalf, MSH will need to know their relationship to you. Depending on the nature of the discussion you may need to provide your express consent for MSH to communicate with a 3rd party.

NOTES