

Urban School Insurance Consortium
(The Policyholder)

Policy No. 100006331

issued by
**Industrial Alliance Pacific Insurance and
Financial Services Inc.**
(The Company)

The Program

A specialized program of hospital/medical insurance to protect you.

Who Is Eligible?

Full-time non-Canadian students under age 70 whose names are on file with the Company and who (a) hold an International Student Visa, (b) are under the administration of the Policyholder, (c) reside in Canada, (d) on the effective date of their coverage are registered in classes at a recognized institution of learning within Canada and have arrived in Canada, and (e) are in good health, have passed all medical requirements to enter Canada and for whom the applicable premium has been paid.

Coverage is mandatory for all eligible persons.

What Does It Cover?

You are covered 24 hours a day for Injury sustained or Sickness occurring while the policy is in force, provided you are registered in classes on behalf of a participating school board of the Policyholder.

"Injury" means bodily injury caused by an accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy.

"Sickness" means sickness or disease occurring while the policy is in force as to the Insured Person whose sickness is the basis of claim.

What Benefits Are Provided?

MEDICAL REIMBURSEMENT EXPENSES

When by reason of Injury or Sickness, you require medical or surgical treatment and incur eligible expenses described below, the Company will reimburse the reasonable and necessary charges for services or supplies received by you as follows:

- (a) hospital expenses up to standard ward accommodations;
- (b) expenses of a nurse, to a maximum of \$500.00 per policy year;
- (c) treatment by a licensed physiotherapist when recommended by a physician, to a maximum of \$1,000.00 per policy year;
- (d) expenses incurred for blood plasma, whole blood or oxygen;
- (e) x-rays and laboratory examinations which are required for diagnostic purposes;
- (f) treatment by a physician or surgeon and anaesthetists' fees specified in the schedule of fees;
- (g) services of a licensed chiropractor, osteopath, chiropractor, podiatrist, massage therapist (when recommended by a physician), speech therapist or psychologist, to a maximum of \$500.00 per speciality per policy year;
- (h) specific dental procedures if performed in a hospital by a dental surgeon appointed to the dental staff of the hospital.

MEDICAL REIMBURSEMENT EXPENSES (Continued...)

The Company will also reimburse the reasonable and necessary charges for services or supplies received by you as follows:

- (a) expenses for an annual health examination;
- (b) expenses for an annual eye examination by a licensed ophthalmologist or optometrist;
- (c) expenses for artificial limbs, eyes or other permanent prosthetic appliances;
- (d) rental of a wheelchair, iron lung and other durable equipment for therapeutic treatment;
- (e) orthopedic shoes if part of a brace, including any fee charged by a physician, to a maximum of \$200.00 for designing and \$100.00 per pair per policy year;
- (f) expenses for hearing aids, crutches, splints, casts, trusses and braces (not dental braces), to a maximum of \$750.00 per policy year.

ACCIDENTAL DENTAL REIMBURSEMENT BENEFIT

When, as the result of Injury to whole or sound teeth (capped or crowned teeth will be considered whole or sound) and due to a force or blow external to the mouth, you require treatment within 30 days from the date of the accident by a legally qualified dentist or dental surgeon, the Company will pay the expenses actually incurred for such treatment or service within 12 months of the date of the accident, subject to a maximum of \$4,000.00. Payments under this part will be made in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the province or territory of the Policyholder or its equivalent, as determined by the Company.

AMBULANCE EXPENSE

Expenses for a licensed ground ambulance service are covered or, when recommended by a physician, for any other conveyance (other than air ambulance) licensed to carry passengers for hire, to or from the nearest hospital which is equipped to provide the required treatment, subject to a maximum of \$1,000.00 per Injury or Sickness. Expenses for a licensed air ambulance are covered, subject to prior approval from the provincial emergency health services and to the maximum specified in the health insurance plan schedule of fees published by the province or territory of the Insured Person's residence.

DENTAL TREATMENT BENEFIT

In the event you require emergency treatment for pain relief, other than from a force or blow to the mouth, the Company will pay the expenses actually incurred by you for such treatment, subject to a maximum of \$500.00. All treatment must be initiated within 48 hours from the time the emergency began and completed no later than 90 days after the treatment has begun. Payments under this part will be made in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the province or territory of the Insured Person's residence.

EMERGENCY OUT-OF-PROVINCE BENEFIT

The Company will reimburse the reasonable and necessary expenses incurred by you for treatment or service as the result of Injury or Sickness while travelling on a trip outside the province or territory of residence, subject to a maximum trip duration of 30 days. All expenses must be incurred on a non-elective emergency basis. Insurance takes effect on the date of departure from the province or territory of residence in Canada and terminates on the earliest of (a) the date of return to the province or territory of residence in Canada or (b) 30 days following the date of departure.

EMERGENCY OUT-OF-PROVINCE BENEFIT (Continued...)

Coverage is not applicable while you are in your country of domicile. Travel to the United States or Mexico during the term of insurance is valid, except for United States residents returning to the United States and Mexican residents returning to Mexico.

FAMILY TRANSPORTATION BENEFIT

In the event you are confined to hospital as an in-patient due to Injury or Sickness and the attendance of a member of your immediate family is certified as medically necessary by the attending physician, the Company will reimburse up to a maximum of \$1,500.00 for transportation costs by the most direct route incurred by such member of your immediate family.

PRESCRIPTION DRUG REIMBURSEMENT

When, by reason of Injury or Sickness, you incur expenses for prescription drugs or medicines prescribed in writing by a physician, the Company will reimburse the actual cost of such prescription drugs or medicines, subject to a maximum of \$10,000.00 per Insured Person per policy year. Drugs or medicines must be prescribed and purchased for use during the term of insurance, subject to a dispensing maximum of a three month supply.

The following are excluded: oral contraceptives; fertility drugs; male pattern baldness remedies; smoke cessation or anti-smoke remedies, including nicotine gum, patches or similar products; medicines which are available without a prescription; problems related to erectile dysfunction (ED); the purchase of food or nutritional supplements and expenses incurred in the treatment of obesity, whether or not these are prescribed for medical purposes; injectable drugs; and experimental drugs.

REPATRIATION BENEFIT

If Injury or Sickness results in your loss of life, the Company will pay the reasonable and necessary expenses actually incurred for transportation of your body to your country of domicile, including the preparation of your body for such transportation, subject to a maximum of \$10,000.00.

RETURN HOME BENEFIT

If Injury or Sickness totally incapacitates you, the Company will pay the reasonable and necessary expenses actually incurred for returning you by the appropriate means of transportation to your country of domicile. All travel arrangements must be approved by the Company prior to departure and are limited to a maximum of \$15,000.00.

Pre-Authorization

Expenses for scheduled confinement in hospital or scheduled surgery, including outpatient surgery, must be submitted to the Company for approval three days in advance of the date of admission. Failure to submit such notification within the prescribed period of time will limit coverage to 70% of all expenses incurred, subject to an overall maximum of \$10,000.00.

Pre-Existing Conditions

The policy will not provide payment or indemnity for expenses incurred directly or indirectly, or resulting from any Pre-existing Condition of the Insured Person.

“Pre-existing Condition” means any condition for which an eligible person received medical advice, consultation or treatment within six months prior to the commencement of insurance, with the exception of a chronic condition which is under treatment and stabilized by the regular use of prescribed medication.

When Does This Insurance Not Apply?

- declared or undeclared war or any act thereof;
- terrorist activity of any kind;
- loss as sole result of utilization of nuclear, chemical or biological weapons of mass destruction;
- active full-time service in armed forces of any country;
- suicide or self-destruction or any attempt thereat (while sane or insane);
- commission or attempt to commit a criminal act by Insured Person;
- treatment for alcoholism or drug addiction;
- participation in professional sports, acrobatic or stunt flying, hang gliding, parachuting, skydiving, parasailing, rock climbing, mountain climbing, bungee jumping, scuba diving, or motorized speed contests;
- hospital visits solely for administration of drugs;
- any service or examination specifically for an application for insurance (or continuance), or an application for a school, camp, association, club, group or program (admission to or continuance at), or employment (application for or continuance of), or legal requirements or proceedings;
- group examination, immunizations or inoculations;
- any physician service or examination for screening, survey or research purposes;
- cosmetic surgery, unless medically required;
- charges for experimental medical treatments;
- acupuncture procedures;
- contraceptive devices of any form;
- treatments and consultations related to infertility;
- voluntary termination of pregnancy;
- pregnancy or childbirth, except complications of pregnancy as provided;
- any elective treatments or surgeries;
- laboratory services or clinical pathology, other than as provided;
- expense of repairing, supplying or replacing eyeglasses, contact lenses or prescriptions therefor;
- expense of dental treatment, nor for the cost of replacement or repair of artificial teeth, dentures, or dental appliances, other than as provided;
- expenses for travelling time or mileage;
- advice by telephone;
- court testimony, preparation of records, reports, certificates or communications;
- any elective medical treatment which means treatment or surgery not required for the immediate relief of acute pain and suffering.

If an Insured Person is entitled to similar reimbursement benefits through any other Insurer or plan, the benefits payable under the policy shall be coordinated, so that the total reimbursement from all Insurers or plans shall not exceed the actual expenses incurred.

Maximum Limit Of Indemnity

With the exception of those benefits listed below, the total amount payable under the policy for reimbursement of all expenses which an Insured Person has incurred for any one policy year will not exceed \$1,000,000.00.

The following benefits are in addition to the Maximum Limit of Indemnity:

Repatriation Benefit
Return Home Benefit

How Do I Make A Claim?

Claim forms are available online at:
<http://www.iapacific.com/group/special/forms/forms.jsp>

During regular business hours, contact the IAP Claims Department at (800) 556-7411 (in Canada and the USA) or at (604) 737-9377 collect (outside North America).

After hours or for medical emergencies, call (800) 255-2008 (in Canada and the USA) or (305) 865-8895 collect (outside North America).

Written notice of death, dismemberment, loss of sight, hearing, paralysis, or loss of use of limbs is to be given to the Insurance Company within a period of 30 days from the date of loss. For all other claims, completed claim forms must be filed with Industrial Alliance Pacific within 90 days after the date of the Injury or Sickness and no later than one year regardless of whether expenses have been incurred. Attach original receipts for all eligible expenses being claimed.

To Whom Are Benefits Paid?

Benefits payable under the policy are payable to the custodial guardian, parent, or if there is none, to the legally appointed guardian when the Insured Person is a minor, otherwise to the Insured Person or the Insured Person's estate.

Underwritten by:
**Industrial Alliance Pacific Insurance and
Financial Services Inc.**



This brochure is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This group Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy, not this brochure.

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SHELL 4322



Urban School Insurance Consortium

International Student Insurance Plan

