

Your Group Benefits Booklet

McGill UNIVERSITY

International students participating in a University Sanctioned Activity (outside Canada)

Group no. 95258

MEDAVIE BLUE CROSS™

List of Benefits

Updated Effective Date: September 1, 2025

Group no. 95258 - International students participating
in a University Sanctioned Activity
(outside Canada)

An overview of your group insurance plan

We are pleased to present your Medavie Blue Cross booklet outlining the coverage you and your dependent(s) are entitled to.

The Emergency Medical Care Benefits, Basic Health Benefits, Supplementary Health Benefits and Leisure Travel Benefit are explained, as well as Accidental Dismemberment and Repatriation. You will find guidelines that will help you claim expenses covered by your group health insurance plan for International students. Additional details on the scope of your coverage are also provided.

Your booklet contains valuable information and should answer most of your questions. We encourage you to read it carefully and to keep it handy for future reference. Remember to carry your insurance certificate with you at all times.

Should you need additional information, please contact the Blue Cross Customer Service at 1 888 588-1212.

This booklet is based on the official texts of the insurance contract governing the Plan. These texts set forth the detailed provisions of the program and take precedence in the event of any conflict with this document.

Finally, please note that the masculine gender has been used indiscriminately throughout this document in order to facilitate its reading.

Eligibility and participation

Who can enrol in the Plan?

You are eligible and have to participate in the Plan if you meet the following conditions:

- you are a student registered at McGill University, covered under contract 95258, and
- you are participating in a «University Sanctioned Activity outside Canada».

You may also enroll your dependent(s) in the Plan, namely your spouse and dependent child(ren), as defined in the following section. If you wish to include your dependent(s), you need to do so when you initially enroll yourself.

When does my coverage become effective?

Your coverage becomes effective on the date you leave Canada for the country of the «University Sanctioned Activity outside Canada».

Coverage for your dependents becomes effective on the date the dependent leaves Canada to reside with you in the country of the «University Sanctioned Activity outside Canada».

When does coverage end for me and my dependent(s)?

You and your dependent(s) stop being covered at the earliest of the following circumstances:

You	Your Dependents
• **when you withdraw from McGill University**	• **when your coverage terminates**
• **on August 31 of any given academic year**	• **the date they are medically evacuated to their Home Country**
• **the date you return to the province of Quebec (whether for a few days or to resume your studies at McGill University). Your coverage then reverts to that of international students residing in Quebec**	• **the date they present a proof of coverage under the Canadian Federal or Provincial government plans**
• **the date you are medically evacuated to your Home Country**	• **the date they return to their Home Country**
• **the date you present a proof of coverage under the Canadian Federal or Provincial government plans**	• **the date they no longer qualify as dependent(s).**
• **the date you return to your Home Country**	
• **the date your status becomes inactive for a reason other than graduation.**	

A dependant's coverage automatically terminates when your coverage terminates, but you may retain your coverage after a dependent's coverage terminates if you continue to meet all conditions of eligibility for coverage.

Definitions

Accident means a sudden, fortuitous and unforeseeable event, resulting directly and independently of any other cause, in bodily injuries certified by a physician and due exclusively to an external cause violent in nature and unintended by the Insured.

Active care means preventive care, medical diagnosis and treatment (including surgery) provided for acute illnesses. It does not include convalescent care and physical or mental rehabilitation.

Contract year means each academic year for the period going from September 1 to August 31 of the next year.

Dependent means the spouse or child who accompanies and resides with you in the country of the «University Sanctioned Activity outside Canada» and who meets the following definition.

a) spouse
person, of opposite sex or same sex, who is:
- legally married to you, or
- designated by you on your application and, with whom you have been living on a permanent basis for at least one year (this period does not apply if a child is born of such union).

At any given time, only one person may be insured as your spouse.

b) dependent child(ren)
unmarried financially dependent child(ren), under 18 years of age.

Expenses incurred following an emergency situation means immediate medical care obtained by the Insured upon the occurrence of a sudden and unforeseeable medical condition which, in the absence of such care, can cause death or severe deficiencies.

To be considered a medical emergency, the illness must necessitate an immediate medical intervention, such as acute appendicitis, asthma attack, kidney stones, cerebrovascular accident, poisoning or convulsions. A medical emergency exists if the following conditions are met:
- symptoms must be sufficiently severe for a reasonable person to call for medical assistance at any time of day or night;
- symptoms must be sudden and unexpected – a chronic condition with moderately acute symptoms which have existed for some time, is not considered a medical emergency. However, if these symptoms suddenly worsen and require immediate medical attention, this condition may qualify;
- immediate care is provided – a medical emergency does not exist if medical care is not obtained as soon as symptoms appear. A telephone call to a physician does not constitute immediate care.

Health professional means any practitioner mentioned in the booklet, who must be a duly registered member of his professional order (if applicable) and practice within the limits of his authority, as established by law. If no professional order is applicable to the practitioner, he must be a duly registered member of an association recognized by the Insurer and provide care and treatments within the limits of his professional competence.

Home Country: The country that issued the passport used by the Insured to enroll at the university and the country in which the Insured maintained permanent residence prior to arrival in Canada if different than the country that issued his passport.

Hospital means a facility licensed as an accredited hospital and offering care and treatments to either inpatients or outpatients. A Registered graduate Nurse (R.N.) must always be on duty, and the hospital must have a laboratory and an operating room where surgical procedures are performed by a legally qualified surgeon. The term "hospital" will on no account mean a facility or part of an accredited facility used primarily as a clinic, extended care facility or part of an extended care facility, rest home, health spa or detoxification centre for drug addicts or alcoholics.

Hospitalization means admission and stay in a Hospital as an in-patient. Day surgery is not considered as a hospitalisation.

Illness (or sickness) means a health deterioration or bodily disorder diagnosed by a physician and which requires regular and continuous care. Such medical care must be considered satisfactory to the Insurer.

Insured means you and any of your dependent(s) insured under this insurance plan.

Insurer means **Medavie Inc.** and **Blue Cross Life Insurance Company of Canada**.

Medical event means a medical treatment or hospitalization which began while the contract is in force. A medical event includes urgent and non-urgent care. If a medical condition necessitates a series of separate treatments and hospitalizations, each treatment or hospitalization will be considered as a distinct event except if

- these treatments or hospitalizations arise from the same immediate medical cause, and
- less than 10 days have elapsed between the end of the medical treatment or hospitalization and the start of the treatment or hospitalization which directly follows.

Physician means a member of the medical profession who is licensed to practice medicine under the laws of the jurisdiction in which he practices. This person must not be a relative of the Insured, nor reside with him.

Pre-existing condition means a medical condition for which the Insured has consulted a physician, been treated by a physician or been prescribed medication during the three-month period preceding the effective date of insurance. For insurance purposes, such a condition will cease to be considered a pre-existing condition on the date the Insured has completed a period of 12 consecutive months following the effective date of insurance without any physician consultation, medical treatment or drug prescription for this condition.

Even if you or your dependent(s) have not consulted a physician during the three-month period preceding your arrival in Canada, the medical condition is considered as a pre-existing condition by the Insurer if the state of health shows obviously that the condition existed at the time of arrival in Canada. Moreover, is also considered a pre-existing condition, any state of condition for which symptoms have been ignored or for which a medical advice has not been followed, or for which recommended investigation treatment, examination or intervention have not been done. The pre-existing condition applies in all cases of congenital disease, whether or not diagnosed.

The pre-existing condition will not apply if this plan replaces a similar coverage that you had with a group insurance plan offered by a recognized Canadian educational institution, for a period of 12 consecutive months immediately prior to the present coverage.

Reasonable and customary means the charges which are usually made in absence of this or any similar coverage, for a specific type or care, service or supply, based on representative fees and prices in a geographic area in which the charges were incurred, as evaluated by the Insurer.

Trip outside the boundaries of the country of the «University Sanctioned Activity outside Canada» means the occasional absence from one's residence in the country of the «University Sanctioned Activity outside Canada» for the purpose of a vacation or leisure.

University Sanctioned Activity outside Canada means study abroad and exchange programs, internships and field study programs in a country other than Canada or your Home Country.

Your Plan at a glance

Your Plan is divided into six categories. A detailed description of each coverage is presented in the following section of this booklet.

Coverage	Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
Emergency Medical Care Benefits	• You • Your spouse • Your dependent child(ren)	100%	None	$1,000,000 lifetime, per Insured, (combined with the Basic Health Benefits)
Basic Health Benefits	• You • Your spouse • Your dependent child(ren))	100% Subject to the maximum specified for each benefit[1]	None	$1,000,000 lifetime, per Insured, (combined with the Emergency Medical Care Benefits)
Supplementary Health Benefits	• You • Your spouse • Your dependent child(ren)	80% Subject to the maximum specified for each benefit[1]	None	$15,000 per contract year, per Insured
Accidental Dismemberment	You	N/A	N/A	Depending on the nature of the injury
Repatriation (in case of death)	• You • Your spouse • Your dependent child(ren))	N/A	N/A	$50,000 per Insured
Leisure Travel Benefit	• You • Your spouse • Your dependent child(ren))	100%	None	$1,000,000 lifetime, per Insured

[1] *Some benefits are limited to the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).*

Types of coverage
- Single (only you)
- Dependent (you and your spouse or you and your dependent child(ren)
- Family (you, your spouse and dependent child(ren) or you and your dependent child(ren))

Extent of coverage

Health benefits are provided on a 24-hour basis, 12 months a year.

The Health Benefit covers:
- physical injury
- sickness
- pregnancy

The medical condition must be certified by a physician.

General exclusions and limitations

No Insured is entitled to benefits with respect to the following:

a) Charges relating to a pre-existing medical condition in excess of $20,000;

b) Injuries or charges arising from the following events:
   - insurrection, war or participation in a riot
   - military service
   - injury or illness resulting directly or indirectly from any force or threat entailing the use of nuclear, chemical or biological agents or weapons by a person, a group of persons or an organization for a political, religious or ideological purpose
   - perpetration of or attempt to perpetrate a criminal offence, including the driving of a motor vehicle, an aircraft or a boat while the alcohol level in the blood is over 80 milligrams in 100 millilitres of blood;

c) Charges incurred while the Insured is not under active treatment by a physician or surgeon;

d) Charges for Basic Health Benefits and Supplementary Health Benefits in excess of the current schedule of fees in the Hospital Insurance Act and the current Provincial Schedule of Fees of the *Régie de l'assurance maladie du Québec (RAMQ)*, unless otherwise specified;

e) Charges related to treatment for aesthetic purposes;

f) Charges by any health specialist not mentioned in this booklet;

g) Services not listed in this booklet;

h) Charges related to immigration medical examinations (physicians' fees, radiological and laboratory examinations etc.).

Coordination of benefits

You and/or your dependent(s) may be entitled to compensation for medical expenses under any other group insurance or a government program such as the Act respecting assistance for victims of crime and similar programs.

If expenses are incurred for medical services of the same nature as those covered under the Emergency Medical Care Benefits and/or the Basic Health Benefits and/or the Supplementary Health Benefits and/or the Leisure Travel Benefit of the Plan, the amount of compensation you and/or your dependent(s) receive from other coverage will be deducted from the eligible expenses you may submit according to the provisions of this Insurance Plan.

Make sure to declare the existence of other coverage by indicating yes or no on the claim form in the appropriate section.

Currency

All payments under this contract, whether to or by the Insurer, will be made in Canadian currency, or if incurred outside Canada, according to the exchange rate in effect when the claim payment is processed.

Important notice

Hospital charges and medical and/or surgical expenses must be incurred with prior approval from Canassistance Inc. The Insurer reserves the right to deny a claim if the Insured has failed to contact Canassistance.

Emergency Medical Care Benefits

The Emergency Medical Care Benefits are eligible if they are incurred following an emergency resulting from an accident or sudden and unexpected illness with occurs within the boundaries of the country of the «University Sanctioned Activity outside Canada».

Coverage	Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
Hospitalization **Out-patient clinic** **Physician's fees** **Diagnostic services** **Drugs** **Ambulance service**	• **You** • **Your spouse** • **Your dependent child(ren)**	**100%**	**None**	**$1,000,000 lifetime, per Insured, (combined with the Basic Health Benefits)**

A) HOSPITAL CHARGES

a) Hospitalization

Expenses incurred by a Insured admitted as an inpatient in a hospital for active care, for his room and board expenses (for a public ward accommodation), physicians' fees, laboratory fees and any other in-patient expenses related to the emergency treatment of the injury or illness, up to the amount that the hospital is entitled to bill the patient directly.

Hospitalization for mental disabilities is subject to a maximum of 30 days (per contract year) for the first event, with an additional 5 days for possible subsequent relapses within the same contract year.

b) Out-patient clinic

Expenses incurred in a hospital outpatient clinic or emergency room.

B) MEDICAL AND PARAMEDICAL EXPENSES

a) Physicians' fees
The fees charged by a physician, surgeon, anaesthetist or radiologist.

b) Diagnostic services
The student and his dependent(s) are covered for the following diagnostic tests:

- laboratory analysis (blood, urine), X-Rays (including CT scans), ultrasounds, and electrocardiograms limited to the current Provincial Schedule of Fees of the *Régie de l'assurance maladie du Québec (RAMQ)*;
- magnetic resonance imaging (MRI), subject to twice the amount specified in the current Provincial Schedule of Fees of the *Régie de l'assurance maladie du Québec (RAMQ)*.
- colonoscopy, limited to the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).

Charges for out-of-hospital diagnostic tests, other than those mentioned above, are not covered.

c) Drugs
The cost of drugs prescribed by a physician and required for an emergency treatment.

d) Ambulance service
The cost of ground or air ambulance, to transport the Insured to the nearest qualified medical facility. This service includes inter-hospital transfer when the attending physician and Canassistance Inc. determine that existing facilities are inadequate to treat the patient or stabilize his condition.

Basic Health Benefits

The expenses listed below are not covered under the preceding section «**Emergency Medical Care Benefits».**

Coverage	Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
Hospitalization **Physician's fees** **Diagnostic tests** **Maternity** **Dental Care (accidental)** **Medical evacuation** **Vision Care**	• **You** • **Your spouse** • **Your dependent child(ren)**	**100% Subject to the maximum specified for each benefit[1]**	**None**	**$1,000,000 lifetime, per Insured, (combined with the Emergency Medical Care Benefits)**

[1] *Some benefits are limited to the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ), unless specified otherwise.*

A) Hospital

PRE-AUTHORIZATION FOR HOSPITAL CONFINEMENT OR SURGERY

Due to limitations in coverage, pre-authorization is always required for hospital confinement or surgery. The necessary forms are to be obtained from the International Student Services Office and completed by the attending physician. They should be submitted to the Insurer for verification. A reply from the Insurer will be provided within 5 working days.

i. Hospitalization (non emergency)

a) Board, room and routine nursing and other services incurred while hospitalized up to the standard ward charge for the hospital. The benefit will be equal to the highest daily standard ward charge applied to Non-Canadians hospitalized in a Canadian hospital, as applicable to teaching hospitals associated with McGill University. Hospitalization for mental disabilities is subject to a maximum of 30 days (per contract year) for the first event, with an additional 5 days for possible subsequent relapses within the same contract year.

b) Expenses incurred for treatment received at the hospital, without hospitalization, subject to an amount equal to the current Provincial Schedule of Fees of the *Régie de l'assurance-maladie du Québec (RAMQ)*.

ii. Hospitalization during a trip outside the country of the «University Sanctioned Activity outside Canada» (subject to the EXCLUSIONS AND LIMITATIONS clause and applicable only in cases where the Leisure Travel Benefit does not apply).

If an Insured must receive non-elective hospital or medical care, the Insurer will reimburse the charges for hospitalization outside the country of the «University Sanctioned Activity outside Canada» only if they are incurred following an emergency resulting from an accident or sudden illness, subject to a maximum of $2,000 per day, in Canadian funds for all services combined, for room and board expenses, physicians' fees, laboratory fees and any other in-patient expenses related to the treatment of the injury or sickness.

B) Physicians' fees (including virtual consultation)

i. Non-elective medical care (Elective care* excluded)

The student and his dependent(s) are covered for charges made by a physician, surgeon, anaesthetist or radiologist, subject to three times the amount specified in the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).

* Treatment that is not medically required.

ii. Preventive medical services

The student and his dependent (s) are covered for charges made by a physician for preventive medical services, subject to three times the amount specified in the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ) and a maximum of one examination per Insured per contract year.

C) Psychiatrists' fees

Charges for treatment by a psychiatrist when referred by the McGill University Student Wellness Hub or by an on or off-campus general practitioner. However, only students, not dependents, may use the Student Wellness Hub to obtain any such referrals. Reimbursement is based on the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ), up to a maximum of $5,000 per person insured per contract year.

D) Pharmacy services

Charges for the same pharmacy services that are eligible, for a Quebec resident, as per the Régie de l'assurance maladie du Québec (RAMQ). The maximum fees established by RAMQ for those services will apply.

E) Diagnostic tests

The student and his dependent(s) are covered for the following diagnostic tests:

- laboratory analysis (blood, urine), X-Rays (including CT scans), ultrasounds, and electrocardiograms limited to the current Provincial Schedule of Fees of the *Régie de l'assurance maladie du Québec (RAMQ)*;
- magnetic resonance imaging (MRI), subject to twice the amount specified in the current Provincial Schedule of Fees of the *Régie de l'assurance maladie du Québec (RAMQ)*.
- colonoscopy, limited to the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).

Charges for out-of-hospital diagnostic tests, other than those mentioned above, are not covered.

Maternity

You (or your pregnant spouse, if applicable) must provide a copy of the results of ultrasound testing indicating the expected date of delivery.

Maternity benefits include:

- Prenatal care and the following tests:
  - medical examinations
  - blood tests
  - urinalyses
  - prenatests and nuchal translucency tests
- Ultrasound performed in a hospital or private clinic
- Prenatal screenings
- Nuchal translucency ultrasounds performed in a hospital
- Costs related to miscarriage or premature delivery or from complications
- Charges for the services of a midwife, subject to a maximum reimbursement of $5,000 per pregnancy. Should any pregnancy complications arise, or for any other valid reason, the Insured may be allowed to switch from a midwife to a physician. Before making such a change, proof and information must be provided, as needed and requested by the Insurer, and pre-approval must be obtained from the Insurer.

  In order for the services of a midwife to be eligible for reimbursement, they must be a registered member of the *Ordre des sages-femmes du Québe*c and practice within the limits of their authority as established by law.
- Delivery, including hospital charges up to the standard ward level and either a physician's or midwife's fees, whichever applies, in view of the conditions specified in the paragraph above.

The above benefits are equal to the amount provided in the current Provincial Schedule of fees of the *Régie de l'assurance maladie du Québec (RAMQ)*.

Maternity benefits also include:

- Therapeutic abortion prescribed by a physician and an intentional termination of a pregnancy before the fetus can live independently (which is currently defined as a maximum of 24 weeks of pregnancy) performed by a physician[1].

The above benefit is subject to the lesser of the amount provided in the current Provincial Schedule of Fees of the *Régie de l'assurance maladie du Québec (RAMQ), or $500*.

[1] Should there be complications of such abortions requiring hospital confinement, hospitalization charges shall be deemed eligible as described in the provisions of item **1. Hospital** of the **Basic Health Benefits** in this section.

Limitations:

Barring complications, the following limitations apply:

- 12 medical examinations per pregnancy
- 3 ultrasounds per pregnancy
- 2 nights of hospitalization for a natural birth

Maternity benefits extend to you and your spouse if you re-register and were already covered under the Insurance Plan for McGill University International Students, or if you or your spouse were previously insured by a similar benefit from a group insurance plan offered by a recognized Canadian educational institution during the previous academic year.

If you or your spouse were not insured during the previous academic year, maternity benefits are not insured if normal delivery takes place during the first 30 weeks following initial registration in the plan. This exclusion does not apply in case of a miscarriage or early delivery, as long as conception occurred during the first 6 weeks immediately prior or subsequent to registration.

You have 30 days from the date of birth of your child to change your coverage according to your new situation (a pro-rata premium adjustment will apply):

- if you initially chose single coverage, you must change to dependent coverage;
- if you initially chose dependent coverage (you and your spouse or you and one child), you must change to family coverage.

F) Dental Care (accidental)

You and your dependent(s) are covered for dental care made necessary due to an accident or when hospitalization is required. X-Rays will be required whenever a claim for dental care is submitted.

The following expenses are covered:

- usual and customary fees for dental treatment of natural teeth when damage is sustained in an accident, provided that treatment is started within 30 days and terminated within one year;

- other dental coverage is restricted to hospitalization while confined as an in-patient - but not as an out-patient - as required for surgical extraction of a tooth and/or care dispensed to complement treatment of the dental condition which necessitated such hospitalization (i.e. impacted wisdom tooth) based on treatment recognized by the Régie de l'assurance maladie du Québec and the Hospital Insurance Act, subject to a maximum reimbursement of $1,000 per Insured, per contract year, for all services combined.

G) Medical evacuation

In the event of medical evacuation, the Insurer will pay up to a maximum of $10,000 for the cost of transportation deemed appropriate by the Insurer for:

- one-way fare to the Insured's Home Country or the Province of Quebec, including stretcher accommodation if required;
- one-way economy airfare for an Insured accompanying an immediate family member being medically evacuated; and
- if deemed medically necessary by the Insurer, in consultation with its medical advisors, round-trip economy airfare for an accompanying medical attendant.

The coordination of care in the Home Country or the Province of Quebec is not the responsibility of the Insurer.

Requested by the Insured

The Insured may request medical evacuation to his Home Country or the Province of Quebec if, in the opinion of the Insurer in consultation with its medical advisors, either of the following conditions are met:

- you have been diagnosed with a medical condition covered under the contract that renders you medically unable to attend courses for at least 30 days in a term; or
- the Insured has been diagnosed with a terminal illness, regardless of whether his medical condition is stable.

Required by the Insurer

The Insurer may require your medical evacuation to your Home Country or the Province of Quebec if, in the opinion of the Insured in consultation with its medical advisors, any one of the following conditions are met:

- you are medically unable to continue your studies because of a medical condition covered under the contract;
- you have been diagnosed with a medical condition covered under the contract that results, or is reasonably expected to result, in your hospitalization for at least 30 days in a term;
- you have an illness or injury covered under the contract which resulted in Hospitalization and requires ongoing treatment from a Physician following discharge; or
- you have been diagnosed with a terminal illness, regardless of whether your medical condition is stable.

The Insurer may require the medical evacuation of an Insured dependent to his Home Country or the Province of Quebec if any of the following conditions are met:

- the Insured dependent has an illness or injury covered under the contract which resulted in Hospitalization and requires ongoing treatment from a Physician following discharge; or
- the Insured dependent has been diagnosed with a terminal illness, regardless of whether his medical condition is stable.

The availability of care in the Insured's Home Country or the Province of Quebec is not considered when assessing whether the Insurer shall require medical evacuation.

If the Insured refuses to be medically evacuated when required by the Insurer, or fails to respond within 5 days of receiving notice from the Insurer that medical evacuation is required, the Insured's coverage shall automatically cease for any expenses that:

- relate directly or indirectly to the illness, injury or medical condition that gave rise to the Insurer's determination that medical evacuation is required; and
- are incurred after the earlier of: (i) the date of the Insured confirms his refusal to be medically evacuated; or (ii) 5 days have lapsed from the date the Insurer provided notice that medical evacuation is required.

Limitation

Notwithstanding any of the above provisions, the Insurer will not require medical evacuation if the Insurer, in the consultation with its medical advisors, deems the Participant's medical condition to be such that it is unsafe to travel.

H) Vision Care

This benefit covers:

- For all Insureds: the fees for one vision test by an optometrist or ophthalmologist per Insured, per contract year.
- For children under age 17: Charges for corrective eyeglasses (frames and lenses) and contact lenses, when prescribed by an optometrist or ophthalmologist, subject to a maximum of $250 per child per 24 consecutive months.

Specific exclusions and limitations

1. Hospitalization and surgery:
   - Charges related to hospital confinement or surgery, when the student has failed to obtain the required pre-authorization;
   - Hospitalization for elective purposes;
   - Organ transplants, whether donor or recipient.
2. Diagnostic tests:
   Analyses and tests for screening purposes

3. Dental Care:
   Charges for dental work performed in a dentist's office or in the hospital, without hospitalization, except when eligible under the above item 6) Dental Care (accidental).

Supplementary Health Benefits

Coverage	Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
Eligible expenses below: **Semi-private room rate** **Prescription drugs** **Vaccines** **Registered nurses** **Physiotherapy** **Paramedical services** **Local ambulance service** **Medical equipment** **Intrauterine device**	• **You** • **Your spouse** • **Your dependent child(ren)**	**80% Subject to the maximum specified for each benefit[1]**	**None**	**$15,000 per contract year, per Insured for all services combined[2]**

[1] *Some benefits are limited to the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).*
[2] *Prescription drugs are not subject to this maximum*.

ELIGIBLE EXPENSES

a) The difference between a semi-private room and a standard ward accommodation in a hospital according to the Schedule of Fees in the *Hospital Insurance Act*.

b) Charges for prescription drugs and medicines, including insulin, needles, reagent strips for diabetes and iron supplements whose availability is restricted to the order of a physician in Quebec and are not offered over-the-counter. However, eligible drugs under this plan may be covered only for the therapeutic indications set forth by Insurer or the *Régie de l'assurance du Québec (RAMQ)*. Drugs are reimbursed up to a 90-day supply.

   Including:

   • For children under age 17: Routine vaccines listed in the Québec's regular vaccination schedule, provided by the Ministère de la Santé et des Services Sociaux (MSSS), subject to a lifetime maximum of $1,000 per child.

- For all Insureds:
  - flu shots;
  - other vaccines, subject to a maximum of $1,000 per contract year;
  - eligible smoking cessation drug products, based on the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).

c) If medically required, out-of-hospital professional services of registered nurses, subject to a maximum of $5,000 per Insured, per contract year.

d) Charges for a physiotherapist, subject to a maximum of $1,500 per Insured, per contract year.

e) Charges of an osteopath, podiatrist and/or chiropractor, subject to a maximum of $500 per Insured, per contract year, for all services combined.

f) Charges of a registered dietician-nutritionist, subject to a maximum of $500 per Insured, per contract year, for all services combined.

g) Local ambulance services, subject to a maximum of $400 per Insured, per contract year.

h) Blood transfusions, artificial limbs and eyes (initial cost only), casts, braces, trusses, crutches, walking aids, rental of standard manual wheelchair, CPAP (Continuous Positive Airway Pressure) and BIPAP (Bi-level Positive Airway Pressure) based on the current Provincial Schedule of Fees of the Régie de l'assurance maladie du Québec (RAMQ).

i) Charges for an occupational therapist or a certified psychologist who is a duly registered member of his psychological association, subject to a maximum of $3,000 per Insured, per contract year, for occupational therapists' and psychologists' fees (including group treatment sessions) and subject to a maximum of $2,500 per insured, per contract year, for assessments tests and analyses carried out by an occupational therapist and a psychologist.

   Eligible charges per visit are limited to the usual and customary rate of a visit.

j) Charges for intrauterine devices and diaphragms, subject to a maximum of $400 per Insured, per contract year, for all items combined.

k) Charges for mammary prostheses when required following a mastectomy, subject to a maximum of 1 prosthesis per 2 calendar years.

Specific exclusions and limitations

No reimbursement will be made under this benefit for the following expenses:

1. Drugs and medical treatment:
   - medicines, professional treatment or injections for the prevention rather than the cure of disease, including, but not restricted to, those received for immigration and travel (except vaccination, which is covered under paragraph b) above);
   - vitamins, fertility and weight control treatments and any related drugs other than contraceptive drugs;
   - sexual stimulants, as well as drugs used to treat erectile dysfunctions;
   - drugs as well as drug formats or preparations without medical necessity;
   - lifestyle treatments.
2. Charges incurred for prosthetic appliances for aesthetic purposes.
3. Charges for podiatric ortheses, insoles, orthopaedic shoes and related treatments.

Accidental Dismemberment

This coverage provides for bodily injuries you may sustain while you are covered under the Plan.

In order to be covered, the injury must be solely due to an external, violent and accidental event. It must result directly, and independently of all other causes, in any one of the losses listed below, within 365 days of the date on which you were injured.

Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
You	**N/A**	**N/A**	**Depending on the nature of the injury**

The Insurer will pay the amount specified hereunder for the injury you sustained provided you are still alive.

NATURE OF THE INJURY	AMOUNT REIMBURSED
Loss of two limbs or both eyes	**$15,000**
Loss of one arm or one leg	**$11,000**
Loss of one complete hand or foot	**$8,000**
Loss of complete sight of one eye	**$2,000**
Loss of thumb or index finger	**$2,000**

If you suffer several losses due to the same injury, only the highest of the applicable amounts will be paid rather than the sum of these amounts.

The complete and irrecoverable loss of use of a limb or complete and irrecoverable loss of sight is treated as complete severing of a limb.

The loss of a fraction of a limb is not covered.

Repatriation (in case of death)

If you or your dependent(s) die while participating in the country of the University Sanctioned Activity outside Canada, the Insurer will pay for funeral and repatriation expenses up to the maximum indicated in the table below.

Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
• **You** • **Your spouse** • **Your dependent child(ren)**	**N/A**	**N/A**	**$50,000 per Insured**

Leisure Travel Benefit

For travel beyond 4 weeks and/or in the student's Home Country, please refer to the Health Benefits section.

Coverage	Who is covered?	Percentage reimbursed	Deductible	Maximum reimbursed
Emergency Hospital and Medical Travel Coverage: **Hospitalization** **Physicians' Fees** **Medical Appliances** **Nursing Care** **Diagnostic Services** **Drugs** **Paramedical Services** **Accidental Dental and Other Dental Emergencies** **Ambulance Service** **Repatriation to the province of Quebec or to the Home Country** **Transportation to Visit the Insured** **Vehicle Return** **Return of the Deceased** **Meals and Accommodation** **Worldwide Travel Assistance** **General Assistance**	• **You** • **Your spouse** • **Your dependent child(ren)**	**100%**	**None**	**$1,000,000 lifetime, per Insured**

Purpose of Coverage

The Insurer will pay the eligible expenses described in this benefit, subject to the conditions outlined below, for a maximum coverage duration period of 4 consecutive weeks. Benefits are paid on a 100% basis without a deductible and up to an overall maximum reimbursement of $1,000,000 per Insured, per lifetime.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *General Conditions* provision of this policy.

Emergency: an illness or injury that requires immediate medical treatment due or related to:

- an injury resulting from an accident;

- a new medical condition which begins during a trip;

- a medical condition that existed prior to a trip provided that it is stable.

Stable means the Insured, in the 90 days before the departure date, has not:

- been treated or evaluated for new symptoms or related conditions;

- had symptoms that increased in frequency or severity, or examination findings indicating the condition has worsened;

- been prescribed a new treatment or change in treatment for the condition (generally does not include reductions in medication due to improvement in the condition, or regular changes in medication as part of an established treatment plan);

- been admitted to or treated in a hospital for the condition; or

- been awaiting new treatments or tests regarding the medical condition (does not include routine tests).

The above criteria will be considered collectively in relation to the overall medical condition.

Hospital: A facility that:

- is licensed as an accredited hospital;
- offers care and treatment to either inpatients or outpatients;
- has a registered nurse on duty 24 hours a day;
- has a laboratory; and
- has an operating room where surgical operations are performed by a legally qualified surgeon.

Coverage excludes any facility used primarily as a clinic, continued or extended care facility, convalescent home, rest home, health spa or drug addiction or alcohol treatment centre unless specifically authorized by the Insurer.

Immediate Family Member: An Insured's parents, spouse, child, brother or sister.

Incident: An individual occurrence of emergency illness or injury.

Travel Companion: Persons who are sharing prepaid travel arrangements with the Insured. No more than 3 persons can qualify as a travel companion for any given Trip.

Trip: Occasional absence from one's residence in the country of the «University Sanctioned Activity» for the purpose of a vacation or leisure.

Trips to and from the student's Home Country and travel in the student's Home Country are excluded.

What the Insurer Will Pay

The Insurer will pay for the expenses explicitly listed in the categories below, subject to the following terms and conditions:

- prior approval of the Insurer must be obtained before the eligible expense is incurred;

- the charges must be usual, customary and reasonable, meaning that:

- the amount charged is consistent with the amount generally charged by health practitioners for similar products or services in the geographical area in which the service or supply is being purchased; and

- the frequency and quantity in which services or supplies are purchased by the Insured are, in the opinion of the Insurer in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Insured's condition;

- payment is limited in accordance with the *Exclusions and Limitations* provision of this benefit;

- payment of this benefit is limited to amounts that are in excess of coverage provided by any other plan (where a court determines that this policy and any other plans provide primary coverage, this benefit will be co-ordinated with the other plan); and

- payment is subject to post-payment audit in accordance with the following provision: The Insurer has the right, at any time, to inspect or audit the health and claim records of the Insured in relation to a claim for benefits. This right to inspect or audit applies to records held by the Insurer or in the files of approved providers and may be exercised by the Insurer or by a third party on behalf of the Insurer.

Emergency Hospital and Medical Travel Coverage

The Insurer will pay the eligible expenses listed in this section if:

- they are incurred as a result of an emergency; and

- the Insurer is satisfied the expense is necessary to stabilize the Insured's medical condition.

Hospitalization: Charges for hospital room accommodation (not a suite of rooms) and for medically necessary inpatient and outpatient services.

Physicians' Fees: Fees charged for physician or surgeon services.

Medical Appliances: The cost of casts, crutches, canes, slings, splints, trusses, braces or the temporary rental of a wheelchair or scooter, when prescribed by the attending physician.

Nursing Care: Fees for private duty nursing performed by a professional nurse or nursing assistant when prescribed by the attending physician. The nurse providing the service must not be a family member of the Insured or an employee of the hospital.

This coverage excludes nursing fees for custodial care.

Diagnostic Services: Charges for laboratory tests, X-rays and diagnostic imaging, when prescribed by the attending physician.

Drugs: The cost of drugs prescribed by a physician, but only in a quantity sufficient to treat the condition for the duration of trip. The Insured must provide satisfactory proof of purchase of this medication that includes:

- the name of the Insured;

- the date of purchase;

- the name of the medication;

- the Drug Identification Number, if available;

- the quantity and strength of the drug; and

- the total cost.

Paramedical Services: The cost of services rendered by chiropractors, osteopaths, chiropodists/podiatrists and physiotherapists. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies: Fees of a dental practitioner for treatment:

a) of damage to natural teeth that occurs as a result of a direct accidental blow to the mouth;

b) that is necessary to repair a fracture or reposition a dislocation of the jaw resulting from an accident; or

c) that is needed to relieve pain caused by an emergency other than those listed in (a) or (b).

With respect to treatment under categories (a) or (b):
- Treatment must begin while the Insured is covered by this benefit and end within 6 months of the accident, unless deferred treatment is approved by the Insurer due to the age of the Insured; and

- the maximum reimbursement per Insured per Incident is $2,000.

With respect to treatment under category (c), the maximum reimbursement per Insured per incident is $200.

Ambulance Service: The cost of ground or air ambulance for transportation of a stretcher patient to the nearest qualified medical facility. This includes the cost of an inter-hospital transfer if the attending physician and The Insurer determine that existing facilities are inadequate for treatment or stabilization.

Repatriation to the province of Quebec or to the Home Country: The cost of repatriating the Insured to the province of Quebec or to their Home Country to receive immediate medical attention, along with the cost of simultaneously returning a travel Companion or any Immediate Family Member covered by the policy. If Medically Necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:
- economy fare to the Insured's home city in Canada; and

- in the case of a medical attendant, round-trip economy fare.

Unless the repatriation or transfer of the Insured is not possible for medical reasons acceptable by the Insurer, the Insurer may require repatriation of any Insured or transfer to other medical facilities. If the Insured refuses repatriation or transfer, all rights to benefits in relation to the incident are terminated.

Transportation to Visit the Insured: The cost of round-trip economy fare (by airline, bus or train) for an Immediate family member to the hospital where the Insured has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. The Insurer may waive the 7-day waiting period if the Insurer is satisfied that this waiver is required.

The cost of round-trip economy fare (by airline, bus or train) for an immediate family member to identify the body of the Insured, if deceased.

Vehicle Return: The fees charged by a commercial agency to return the Insured's vehicle, whether private or rental, to the Insured's residence or to the nearest appropriate vehicle-rental agency, when the Insured is unable to drive as a result of an emergency illness or injury. A medical certificate from the attending physician confirming the Insured's medical incapacity to operate the vehicle is required. This benefit is subject to a maximum of $1,000 per Trip.

Return of the Deceased: The cost of preparing and transporting the remains of the deceased Insured to their province of residence or to their Home Country, to a maximum of $10,000.

Meals and Accommodation: The cost of commercial accommodation and meals when the Insured's travel is delayed due to emergency illness or injury of the Insured or travel companion. The medical reason for the delay must be

verified by the attending physician. The maximum reimbursement is $150 per Insured per day for a maximum of 20 days (up to a total maximum of $3,000 per incident).

All costs must be supported by receipts from commercial organizations.

Worldwide Travel Assistance

The Insurer, through its travel assistance provider, will provide an emergency toll-free line available 24 hours a day, 7 days a week, for Insureds who need medical assistance or general assistance while travelling.

Medical Assistance

If the Insured requires hospitalization or a consultation with a physician as a result of an emergency, the travel assistance provider appointed by the Insurer will provide the following support services:

- direct the Insured to an appropriate clinic or Hospital;

- confirm with the service provider that the Insured is covered;

- ensure a follow-up of the medical file and communicate with the Insured's family physician;

- co-ordinate the return home of a child if the Insured is hospitalized;

- repatriation of the Insured to the province of Quebec or to their Home Country if the Insured meets the eligibility requirements of this expense;

- arrange for the transportation of an immediate family member to the Insured's bedside if the Insured meets the eligibility requirements of this expense; and

- co-ordinate the return of the Insured's vehicle if the Insured meets the eligibility requirements of this expense.

General Assistance

In emergency situations, the travel assistance provider appointed by the Insurer will also provide the Insured with the following services:

- transmittal of urgent messages;

- co-ordination of claims;

- services of an interpreter for emergency calls;

- referral to legal counsel in the event of a serious accident;

- settlement of formalities in the event of death;

- assistance with the loss or theft of identity papers; and

- information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available.

The Insurer and its travel assistance provider are not responsible for the quality of medical and hospital care provided to the Insured or for the availability of such care.

Payment of Claims

How Payments are Made

The Insurer may approve payment directly to the service provider. In certain circumstances, the Insured will pay the full cost of any eligible expense at the time of purchase. The Insurer will then reimburse any eligible expenses on receipt of proof of payment from the Insured.

Time Limit to Submit a Claim

Emergency Hospital and Medical Travel Coverage:

The Insurer must receive proof of claim within 4 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit.

The Insurer will accept claims up to 12 months from the date the expense was incurred. However, in such circumstances, the claim may be subject to reductions for any amounts the Insurer would have been able to co-ordinate with the Participant's government health care coverage had the claim been submitted within the 4-month limitation period.

Exclusions and Limitations

Exclusions Applicable to all Travel Benefit Claims

No payment will be made if:

a) the Insured fails to communicate with the Insurer in the event of medical consultation or hospitalization following an injury or Illness;

b) expenses are incurred beyond the coverage duration period of 4 consecutive weeks;

c) the purpose of the trip is primarily or incidentally to seek medical advice or treatment, even if this trip is on the recommendation of a physician;

d) expenses have already been paid by or are eligible for refund from a third party;

e) expenses are incurred while travelling in the student's Home Country;

f) expenses are incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning to avoid all travel or avoid non-essential travel, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; or

g) expenses are incurred as a result of:

   i. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;

   ii. an illness or injury that occurred while operating a vehicle under the influence of any intoxicant or with a blood alcohol level that was proven to be in excess of the legal limit in the jurisdiction in which the accident occurred;

   iii. an injury or Illness resulting from non-compliance with medical treatment or therapy that has been prescribed; or

   iv. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.

Specific Exclusions and Limitations

Emergency Hospital and Medical Travel Coverage

No payment will be made for:

a) expenses for any care, treatment, surgery, products or services that:

   i. are not incurred as a result of an emergency;

   ii. are not medically necessary;

   iii. are performed for cosmetic purposes only;

   iv. are not required for the immediate relief of acute pain and suffering; or

   v. could be delayed until the Insured's return to Canada;

b) expenses incurred due to pregnancy or pregnancy complications that occur within 8 weeks of the expected date of delivery; or

c) expenses incurred due to an emergency that occurs while participating in:

   i. a sport for remuneration;

   ii. a motor vehicle or speed contest of any kind; or

   iii. any extreme Sport, defined as an activity with a high level of inherent danger and which often involves speed, height, a high level of physical exertion, highly specialized gear or spectacular stunts.

Pre-existing condition: An illness:

- that begins within 12 months of the date the Insured obtained coverage under this benefit; and
- for which, in the 12 month before the date the Insured obtained coverage under this benefit, the Insured has:
  - had a medical consultation;
  - been prescribed or taken medication; or
  - received treatment, including diagnostic services.

Your claims

It is the Insurer' objective to pay claims fairly and promptly. You can facilitate the payment of your claims by following these guidelines.

COMPLETING THE CLAIM FORM

1. Claims related to the Health Plan

Please make sure to indicate the following information on the claim form:

- your name
- your dependent's name if you are claiming for your spouse or child
- your contract number: 95258
- your card number (student ID number)
- the date the services were rendered to you or your dependent
- the nature of the service rendered
- the itemization of charges;
- for prescription drugs:
  - the date of purchase
  - physician's name
  - type of medication
  - prescription number
  - person receiving the treatment (either you or your dependent(s).

eClaims
Claims can also be submitted online by scanning or taking a photo of your receipts and submitting them through the secure Member Services site: www.medaviebc.ca or Medavie Blue Cross Mobile App: www.medaviebc.ca/app Visit International Student services website at: www.mcgill.ca/internationalstudents/health/claims/eclaims for step-by-step instructions

2. Claims related to Accidental Dismemberment

Please contact the Blue Cross Customer Service to obtain the appropriate claim form. Once completed you should send the form to Blue Cross with a written proof of the occurrence of loss giving rise to such claim, within 365 days following the date of such loss.

3. Claims related to repatriation in case of death

Please contact the Blue Cross Customer Service to obtain the appropriate claim form. Once completed, the form should be sent to Blue Cross with a written proof of death of the person insured as soon as possible.

Failure to file the aforesaid claims within the said limited period does not invalidate or diminish any claim hereunder, if it is shown not to have been reasonably possible to file such claim and that it was filed as soon as reasonably possible.

The Insurer is entitled at any time and from time to time to require that you submit to examination by a medical examiner appointed by the Insurer. In the absence of any legal restriction the Insurer will also be entitled in the event of the death to cause an autopsy to be performed.

Claims under any benefit must be received by Blue Cross Insurance no later than 90 days after the end of the policy year in which the claims were incurred or 90 days after the end of your coverage, whichever is sooner. Full-year coverage ends Aug. 31, 2021.

If you are submitting claims for services incurred before Sept. 1, 2020, your claims must be received by Blue Cross Insurance by Nov. 29, 2020. If you are submitting claims for services incurred on Sept. 1, 2020 and onwards, your claims must be received by Blue Cross Insurance by Nov. 29, 2021. Be sure to leave adequate time for delivery.

Payment

The Insurer will make any refund by means of a cheque in the name of the provider of services and/or the student or assignee, after receiving and assessing the relevant invoices and the necessary information pertaining thereto, in accordance with the terms and conditions provided herein. However, in all cases, the Insurer reserves the right to pay the provider of services directly.

Any amount paid by the Insurer or on its behalf relieves the Insurer of all obligations, to the extent of such amount.

Privacy

In the course of providing customers with quality health, life and travel coverage, Medavie Blue Cross collects, uses and stores certain personal information about its members and their dependents. Protecting personal information is not new to us. Ensuring the privacy of client information has always been fundamental to the way we do business.

The purpose of our **privacy statement** is to keep you informed about privacy protection practices at Medavie Blue Cross. In addition to this privacy statement, we have an **online privacy statement** that describes our practices for protecting your personal information when you use our websites and mobile applications and a **Medavie Blue Cross mobile app privacy policy** that applies to your use of our mobile app.

For more information on our privacy protection practices, please visit our website. **medaviebc.ca.**

Legal considerations

Waiver of liability

As a condition precedent to the providing of benefits under the Emergency Medical Care, Basic and Supplementary Health Benefits and Leisure Travel Benefit, the Insurer will be held free of any liability for any act or omission of any hospital or any other person rendering any of the service provided thereunder.

False pretenses

The rights of a person insured to benefits under the contract will terminate automatically if such person insured should aid any person in obtaining or attempting to obtain by false pretenses any benefits hereunder and the Insurer will be immediately relieved of all liability for expenses, otherwise eligible, incurred after the date of termination of such rights.

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This plan for International Students at McGill is administered by International Student Services.