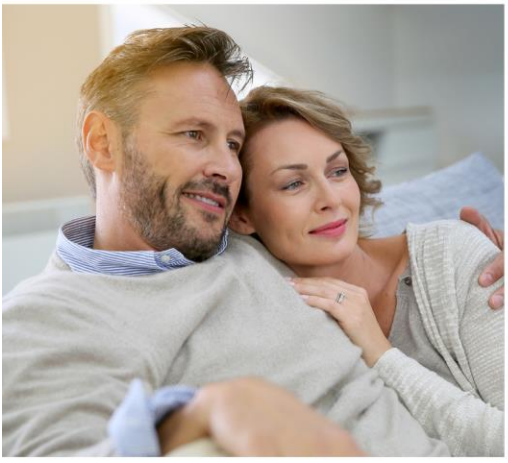

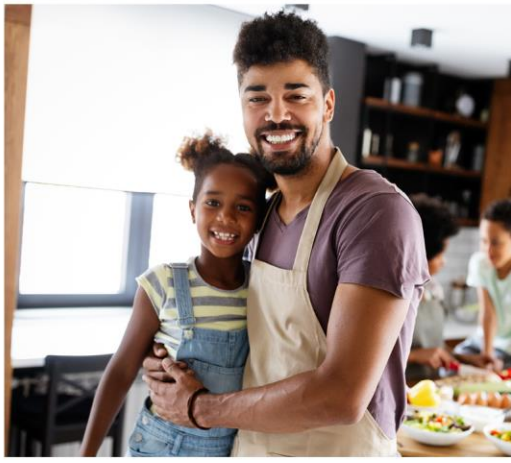

Your Group Benefits Booklet

St. Clair College

International Students

Plan Number:
99586

Effective Date:
September 1, 2022

MEDAVIE BLUE CROSS™

Welcome to your Student Benefits Plan

Your Student benefits coverage provides you with the peace of mind that you and your family are protected today and in the future, for health and medical expenses not available through the coverage provided by government.

This program is insured by Medavie Inc. (also known as Medavie Blue Cross) and Blue Cross Life Insurance Company of Canada, which together will be referred to as "Blue Cross" for convenience of reference.

Medavie Blue Cross insures all health benefits. All other benefits are insured by Blue Cross Life Insurance Company of Canada.

Blue Cross has been a trusted health services partner for individuals, plan administrators and governments across Canada for over 70 years. Our core purpose is to help improve the health and well-being of people and their communities.

Our commitment to service, innovative solutions and technological expertise mean you can rest easy because at Blue Cross, we're always there for you.

About this Booklet

This booklet, together with your identification card, contains important information about your Student benefits coverage. You should keep them in a safe place for future reference.

This booklet summarizes the important features of your Student benefits coverage. It is prepared as information only, and does not, in itself, constitute an agreement. The exact terms and conditions of your Student benefits coverage are described in the benefit plan held by your plan administrator. In the event of a difference of wording of the benefit plan, the benefit plan will prevail, to the extent permitted by law.

Helpful Tip

Take a tour in the Member Centre section at **www.medavie.bluecross.ca**

Your booklet is divided into the following sections:

- **Summary of Benefits:** Outlines the main features of each benefit. It is important to read your Summary of Benefits along with the benefit details to ensure you fully understand your benefit coverage.
- **Coverage Details:** Contains important information regarding the eligibility requirements for your Student benefits coverage. This includes when your coverage begins and ends, plus other useful information to help you take advantage of the coverage available to you.
- **Rights and Responsibilities under the Policy:** Outlines your responsibilities under the benefit plan (such as your responsibility to notify your plan administrator upon change in status) and your rights (for example your right to privacy).
- **How to Submit a Claim and Obtain More Information:** Provides additional information on how you can submit claims and obtain more information regarding your coverage.
- **Helpful Tips:** Throughout this booklet we provide useful tips to help you better understand and get the most out of your Student benefits.

TABLE OF CONTENTS

Summary of Benefits

Emergency Health Care Benefits

Extended Health Care Benefits

Overall Policy Maximum	$5,000,000/Policy Year combined with Hospital, Drug, Dental, Travel and Member Accidental Death and Dismemberment

	Reimbursement Level	Benefit Maximum	Accommodation
Hospital Benefits			
Hospital Room	100%		Semi-private
Psychiatric/Psychological Hospitalization	100%	$60,000/lifetime; see benefit details	
Inpatient Psychiatry Services	100%	$60,000/lifetime; see benefit details	
Tutorial Service in Hospital	80%	$20/hour up to $2,000/Policy Year	
Medical Services and Supplies			
Ambulance Transportation			
Ground Emergency	100%	$10,000/ Policy Year	
Air Emergency	100%	$300,000/Policy Year	
Taxi Fare in lieu of Ambulance	100%	$5,000/Policy Year	
Nursing Care	100%	$15,000/Policy Year	
Custom Orthopedic Shoes	80%	$400/Policy Year; see benefit details	
Custom Made Foot Orthotics (due to injury)	80%	$400/Policy Year; see benefit details	
Hearing Aids (due to injury)	100%	$400/Policy Year	
Diagnostic Tests	100%	See benefit details	

Summary of Benefits

Emergency Health Care Benefits

Extended Health Care Benefits

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Accidental Dental and Other Dental Emergencies	100%	Predetermination of claim required, see benefit details
Accidental Damage to Sound Teeth	100%	$4,000/Policy Year
Relief of Dental Pain	100%	$1,000/Policy Year
Extraction of Impacted Wisdom Teeth	100%	$100/tooth/Policy Year
Repatriation – Return of the Deceased or Burial/Cremation	100%	$20,000; see benefit details
Ongoing/Non-Emergency Care	100%	Included; see benefit details
Maternity Expenses	100%	$25,000/Policy Year; see benefit details
Tuition Reimbursement	100%	$5,000/Policy Year
Wart Treatment	100%	$500/Policy Year
Elective Testing for Sexually Transmitted Infections	100%	$400/Policy Year; see benefit details
Corrective Device Defect, Malfunction or Theft	100%	$1,000/Policy Year; see benefit details
Other Medical Services and Supplies	80%	$250/lifetime; see benefit details
Special Treatment Travel Expenses	100%	$1,000/Policy Year

Summary of Benefits

Non-Emergency Health Care Benefits

Extended Health Care Benefits

Medical Services and Supplies	Reimbursement Level	Benefit Maximum
Eye Examination	100%	$100/12 consecutive months
Glasses (Lenses, Frames)/Contact Lenses (due to injury) (combined)	100%	$150/24 consecutive months
Physician Visits for Specific Purposes		
Annual Physical (Check-up)	100%	1 examination/12 consecutive months
Birth Control-Related	100%	$100/Policy Year; see benefit details
Acne-Related (dermatologist)	100%	$200/Policy Year; see benefit details
Attention Deficit Hyperactivity Disorder Treatment	100%	$300/Policy Year
Durable Medical Equipment	100%	See benefit details
Mobility Aids and Orthopedic Appliances	100%	See benefit details
Leg Brace (due to injury)	100%	$1,000/Policy Year

Summary of Benefits

Emergency Health Care Benefits

Extended Health Care Benefits

	Reimbursement Level	Benefit Maximum
Health Practitioners:		
Physician/Surgeon/Anaesthetist	100%	Included see benefit details
Mental Health Practitioners:		
Psychiatrist/Psychologist/General Practitioner for Psychiatric Counselling (Outpatient)	100%	$10,000/Policy Year
Counselling Therapist/Psychoeducator (Trauma Counselling)	100%	6 sessions/Policy Year; see benefit details
Social Worker	100%	$500/Policy Year
Chiropractor	100%	$1,000/Policy Year (includes x-rays)
Naturopath	100%	$1,000/Policy Year (includes x-rays)
Acupuncturist	100%	$1,000/Policy Year
Osteopath	100%	$1,000/Policy Year (includes x-rays)
Chiropodist	100%	$1,000/Policy Year (includes x-rays)
Dietician/Nutritionist	100%	$1,000/Policy Year
Podiatrist	100%	$1,000/Policy Year (includes x-rays)
Speech Therapist	100%	$1,000/Policy Year
Physiotherapist	100%	$1,000/Policy Year
*Massage Therapist**	100%	$1,000/Policy Year
Athletic Therapist	100%	$1,000/Policy Year

*When prescribed by a Physician.

Summary of Benefits

Emergency Health Care Benefits

Prescription Drugs

Overall Policy Maximum	$5,000,000/Policy Year combined Hospital, Extended Health Care, Dental, Travel and Member Accidental Death and Dismemberment
Overall Drug Benefit Maximum	$2,500/Policy Year
Reimbursement Level	100% for generic drugs or 90% for brand drugs from Direct2U prescription delivery 80% for generic drugs or 60% for brand drugs at all other pharmacies
Dispensing Fee Maximum	$8 (Direct2U prescription delivery) $5 (All other pharmacies)
Method of Payment	Pay Direct
Stability Requirement	90 days - Prescriptions eligible for coverage and reimbursement that are related to a pre-existing medical condition does not confirm or guarantee eligibility of the medical coverage for said condition. All medical coverage is subject to a 90 day stability clause of any pre-existing medical condition
Drug Formulary	Open Formulary
	Benefit Maximum
Days Supply	100-days maximum supply (1-month supply may apply to some drugs), on an outpatient basis
Plan Management Features	Mandatory Generic Substitution
Quebec Pharmacy Pricing Controls	Usual, Customary and Reasonable applies
Opioid Management	Included
Additional Benefit Modules	**Benefit Maximum**
Vaccines/Immunizations	$100 per prescription*
Glucose Monitoring Systems	$2,500/Policy Year*
Managing Chronic Disease	$500/Policy Year*
Diabetic Supplies	$200/Policy Year; See benefit details*
Termination	When the Member reaches age 65

*Included in the overall Drug Benefit Maximum.

Summary of Benefits

Emergency Health Care Benefits

Dental Benefits

Overall Policy Maximum	$5,000,000/Policy Year combined with Hospital, Drug, Extended Health Care, Travel and Member Accidental Death and Dismemberment	
Fee Guide Schedule	Current year/Province of Provider (Specialist fees included)	
	Reimbursement Level	**Benefit Maximum**
Preventive Care	80%	$500/Policy Year combined with Basic Care and Major Restoration
Oral Exam and Diagnosis		
Recall oral exams		1/12 consecutive months
Preventive Treatment		
Polishing of teeth		1/12 consecutive months
Fluoride treatment		1/12 consecutive months
Scaling		2 Units/12 consecutive months (combined with Root Planing)
Basic Care	80%	$500/Policy Year combined with Preventive Care and Major Restoration
Fillings		Included
Extractions		Included
X-rays		Included
Periodontic Services		
Root Planing		2 Units/12 consecutive months (combined with Scaling)
Major Restoration	80%	$500/Policy Year combined with Basic Care and Preventive Care
Restorative Services		See benefit details
Lowest Cost Alternative Benefit	Inlays and crowns	
Termination	When the Member reaches age 65	

Summary of Benefits

Emergency Health Care Benefits

Travel Outside Canada

Overall Policy Maximum	$5,000,000/Policy Year combined Hospital, Drug, Extended Health Care, Dental and Member Accidental Death and Dismemberment
Reimbursement Level	100%
Coverage Duration	
Trip to Home Country	First 31 days of Trip outside Canada
Trip to any other country (Leisure Purposes)	First 120 days of Trip outside Canada
Trip to any other country (Academic Purposes)	First 180 days of Trip outside Canada if 51% of Policy Year is spent in Canada
Transportation for Family to Visit the Participant	Included; see benefits details
	Benefit Maximum
Emergency Hospital and Medical Travel Coverage	$2,000,000/Participant/Incident*
Termination	When the Member reaches age 65

*Incident: An individual occurrence of Emergency illness or injury.

Summary of Benefits

Member Accidental Death and Dismemberment Benefit

Overall Policy Maximum	$5,000,000/Policy Year combined with Hospital, Drug, Extended Health Care, Dental and Travel
Benefit Formula	Flat amount
Benefit Maximum	$50,000; see benefit details Exception: If the Loss is due to a Common Carrier Accident, the benefit maximum is $100,000
Termination	When the Member reaches age 65

Emergency Health Care Benefits

Emergency Health Care benefits include the Prescription Drugs and Travel Outside Canada subcategories.

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit (including the Prescription Drug and Travel Outside Canada sections), if they are incurred as a result of an Emergency (unless otherwise specified), subject to the conditions outlined below.

COVID-19

Blue Cross will pay the Eligible Expenses directly related to COVID-19 medical expenses, provided that the Participant contracted the illness after arriving in Canada, and the Participant:

- was not experiencing symptoms within 14 days of departure from their Home Country;
- did not receive a positive test result for COVID-19 (and was not waiting for test results) within 14 days of arrival in Canada; and
- was not in contact or notified as a close contact with anyone who tested positive in the 14-day period prior to arriving in Canada.

Helpful Tip

Blue Advantage® offers savings to Blue Cross members on medical, vision care and many other products and services from participating providers across Canada.

A list of participating providers and discounts is available at **www.blueadvantage.ca**.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Acute Care: Short-term Treatment that is necessary to:

- prevent deterioration of a severe injury, episode of illness or urgent medical condition;
- promote recovery from surgery; or
- provide palliative care for an individual diagnosed with a terminal illness whose life expectancy is less than 3 months.

Hospital: An Acute Care facility that is licensed to provide inpatient treatment. This does not include any part of such facility that is intended for long term care. The facility must:

- have facilities for diagnostic treatment and major surgery;
- qualify to participate in and be eligible to receive payments under the provisions of the provincial hospital act in the jurisdiction in which it is located, if in Canada;
- operate in accordance with the applicable laws of the jurisdiction in which it is located;
- provide 24 hour nursing care services; and
- require that every patient be under the direct care of a physician.

Hospitals do not include convalescent care facilities, physical or psychiatric rehabilitation facilities, maternity homes, nursing homes, rest homes, retirement residences, homes for the aged, blind, deaf, chronically or mentally ill, long-term care or assisted living facilities or drug addiction and alcohol treatment centres. It also does not include any part of a Hospital consisting of nursing care or beds that have been set aside for any of the purposes outlined in this paragraph.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the reimbursement level and benefit maximums specified below and in the Summary of Benefits; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

Hospital Benefits

Hospital Room: Room accommodation when a Participant is admitted to a Hospital as an inpatient for Acute Care or Medically Necessary emergency or outpatient services. The type of room eligible for coverage is specified in the Summary of Benefits.

Psychiatric/Psychological Hospitalization: Room accommodation when a Participant is admitted to a Hospital due to psychological, mental or emotional disorders, suicide, any attempt at suicide, intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury. Coverage under this category also includes psychiatry services provided on an in-patient basis during the term of hospitalization under this benefit to a maximum specified in the Summary of Benefits, as well as the cost of the initial Physician visit leading to this hospitalization.

Helpful Tip

Ask your Health Practitioner if they are a Blue Cross Approved Provider before you obtain service or supplies to avoid unexpected out-of-pocket expenses.

Tutorial Service in Hospital: Charges for a qualified private tutorial service during a period of hospitalization in excess of 30 consecutive days. Expenses must be incurred within 365 days from the date of Illness.

Hospital coverages exclude administrative and incidental fees (for example, television, telephone and parking).

Medical Services and Supplies

Ambulance Transportation: Charges for emergency transportation of a stretcher patient by a licensed ambulance to and from the nearest Hospital equipped to provide the emergency care needed by the Participant. This includes air or rail transportation, as well as taxi fare in lieu of ambulance transportation.

Nursing Care: Charges for the services of a registered nurse, registered nursing assistant or licensed practical nurse where such services are provided at the Participant's home and are not primarily for custodial care or midwifery.

Nursing care services may require pre-approval from Blue Cross to be eligible for payment in whole or in part.

Helpful Tip

Before receiving nursing services you should obtain pre-approval from Blue Cross by contacting the toll-free number on your identification card.

This coverage excludes expenses for custodial care, homemaking duties, shopping, transportation, respite care and services not related to the Activities of Daily Living.

Health Practitioners: Eligible Expenses for Treatment provided by any Health Practitioner specified in the Summary of Benefits, when deemed essential on an Emergency basis. Coverage is limited to:

- Treatment within the scope of the Health Practitioner's practice; and
- 1 Treatment by the same Health Practitioner per day.

Health Practitioner services received as an outpatient or at a private clinic are covered under the practitioner maximums specified in the Summary of Benefits.

Health Practitioner services received in Hospital as an inpatient are covered under the overall policy maximum.

This coverage excludes:

- products provided by a Health Practitioner (unless specified as a benefit under this Student benefits plan);
- comprehensive health assessments; and
- group treatment sessions.

Physician/Surgeon/Anaesthetist: Charges for the services of a qualified Physician, surgeon or anaesthetist who is not an Immediate Family Member of the Participant.

Mobility Aids and Orthopedic Appliances: Charges for the rental of crutches, canes and walking aids, casts, splints, trusses and braces and cervical collars.

Prostheses: Charges for the following prosthetic appliances:

- standard artificial limbs or myoelectric limbs;
- artificial eyes;
- artificial nose;
- breast prosthesis when needed following a mastectomy; and
- wigs when hair loss is due to an underlying pathology or its Treatment.

Repair or adjustments of eligible prosthetic appliances.

This coverage excludes:

- microprocessor knees;
- wigs when hair loss is not due to an underlying pathology or its treatment, hair replacement therapy and other procedures for physiological hair loss (for example, male pattern baldness); and
- replacement of prostheses unless required due to pathological or physiological change.

Hearing Aids: Charges for the purchase and repair of hearing aids due to injury, when prescribed by an otorhinolaryngologist or otologist or recommended by an audiologist to a combined maximum for both ears.

This coverage excludes batteries and exams.

Custom Orthopedic Shoes and Foot Orthotics: Charges for:

- the purchase and repair of custom made orthopedic shoes or prefabricated orthopedic shoes with permanent modifications to accommodate, relieve or remedy a mechanical foot defect or abnormality provided that:
  - the shoes have been prescribed by an attending physician, orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist;
  - the Participant provides a copy of the biomechanical or gait analysis from the prescribing Health Practitioner; and
  - the shoes are dispensed by an Approved Provider of orthopedic shoes.
- custom made foot orthotics to accommodate, relieve or remedy a mechanical foot defect or abnormality providing that:
  - they have been prescribed by an attending physician, an orthopedic surgeon, physiatrist, rheumatologist or chiropodist/podiatrist; and
  - they are dispensed by an Approved Provider of custom made foot orthotics.

Helpful Tip

For more information on which expenses qualify under your orthopedic shoes and orthotics coverage, visit our website. www.medaviebc.ca/benefit updates.

This coverage excludes the purchase and repair of pre-fabricated orthopedic shoes without permanent modifications.

Diagnostic Tests: Charges for the following diagnostic tests when provided by a laboratory approved by Blue Cross:

- laboratory analyses; and
- diagnostic imaging services (ultrasounds, electrocardiograms, computerized tomography (CT Scans), X-rays and magnetic resonance imagery (MRI)). Expenses must be incurred in Canada.

This coverage excludes charges for diagnostic services if they are incurred for the purpose of health screening.

Other Medical Services and Supplies: Charges for the following medical services and supplies to the overall maximum specified in the Summary of Benefits:

- allergy testing materials;
- purchase of an artificial larynx;

- repair of an artificial larynx;
- burn pressure garments;
- graduated compression garments (including stockings);
- intrauterine contraceptive device (IUD);
- ostomy supplies, catheters and catheterization supplies;
- oxygen;
- spacing device;
- speech aid equipment for persons who do not have oral communication ability, when approved by a qualified speech therapist and authorized by the attending physician;
- sleeves for lymphedema;
- surgical brassieres; and
- transcutaneous electrical nerve stimulator (TENS) device.

Contact Lenses Due to Disease: Contact lenses due to ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal degeneration of the cornea to a maximum of $400 per Policy Year. The contact lenses must improve sight to at least 20/40 and this level of improvement must not be possible with eyeglass lenses.

Special Treatment Travel Expenses (Non-emergency Transportation): Charges for non-emergency transportation to and from the nearest Hospital, medical facility or specialist, when a Participant requires medical services which are not readily available in their area. The medical services must be prescribed by an attending Physician.

Accidental Dental and Other Dental Emergencies: Charges for:

a) dental Treatment when required to repair or replace a sound natural, or permanently attached artificial, tooth. To be eligible for coverage, Treatment must be required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting. A tooth is considered sound if, before the accident:
   - it was free from injury, disease or defect;
   - it did not need further restorations to remain intact or hold secure; and
   - it had no breakdown or loss of root structure or loss of bone, and

b) dental Treatment that is needed to relieve pain caused by an Emergency other than for the reason listed above; and

c) the extraction of impacted wisdom teeth.

Accidental dental and other dental emergencies benefit is subject to the maximum specified in the Summary of Benefits.

To be eligible for coverage, Treatment must be:

- incurred while covered for accidental dental benefits with the plan administrator;
- initiated within 7 days of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for approval within that period; and
- performed within 90 days of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

Helpful Tip

Coverage amounts are determined by the fee guide for dental general practitioners applicable to the dentist's province of practice in the year expenses are incurred.

This coverage excludes accidental damage to teeth that occurs while eating.

Repatriation – Return to Home Country: The cost of repatriating the Participant to their Home Country to receive ongoing care or for recovery purposes, if in relation to Treatment of an Illness received under this policy, to a to a maximum of $20,000 per Policy Year. If Medically Necessary, this cost may include an accompanying medical attendant.

If returning on a commercial aircraft, coverage includes:

- one-way fare to the Participant's Home Country, including stretcher accommodation if required; and

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

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

Repatriation – Return of the Deceased: The cost of preparing and transporting the remains of the deceased Participant to their city of residence in their Home Country.

Repatriation – Burial/cremation: The cost of preparing the body for burial or cremation and shipping the body to the place of burial or cremation or bury or cremate the body at the place of death.

On receipt of written proof of anticipated expenses, Blue Cross may make an advance payment, provided that the plan sponsor confirms to Blue Cross:

- the name of the Member and the date and cause of death; and
- that the Member was eligible for this benefit on the date of death.

This coverage excludes the cost of a coffin.

Ongoing/Non-Emergency Care: Charges for expenses incurred for ongoing or non-Emergency medical Treatment, including Medically Necessary treatment following an initial Emergency.

Maternity Expenses: Charges for expenses incurred resulting from the pregnancy of a Participant commenced during the Policy Year (or within 60 days from it beginning), for a maximum period of 6 months following the birth of the child.

This coverage includes spontaneous, or non-induced, pregnancy terminations. Induced terminations are limited to one per Policy Year.

Eligibility for coverage under this category is based upon the conception date of the pregnancy, whether known or unknown to the Participant, and only when coverage has been in force for the entire term of the pregnancy.

Tuition Reimbursement: In the event of an Emergency which prevents you from attending your classes and, upon receipt of proof of tuition payment from you, minus any amounts refunded by your educational institution, Blue Cross will reimburse up to the maximum specified in the Summary of Benefits. Confirmation that you are unable to obtain passing grades is required in writing by your physician and registrar of the Participating Educational Institution you are attending.

Wart Treatment: Charges for expenses incurred for the treatment of any type of warts.

Elective Testing for Sexually Transmitted Infections: Charges for expenses incurred for elective testing for sexually transmitted infections, including lab work and one consultation for the prescription of the 'morning after pill' provided that the plan coverage period is a minimum of 4 months.

Trauma Counselling: Charges for expenses incurred for trauma counselling commenced within 7 days and concluded within 90 days of an Emergency occurring during the Policy Year.

Corrective Device Defect, Malfunction or Theft: Charges incurred for the repair or replacement of any corrective device provided as part of a benefit under this policy if the device becomes unusable, or is stolen, during the Policy Year.

The corrective device must have been recommended by the Participant's treating Physician to correct a physical disability of the sort that would exclude the Participant from being able to participate in his or her studies, teaching or other important life responsibilities.

Coverage under this category excludes defects or malfunctions which were evident prior to the Policy Year, or those covered by other insurance plans including manufacturer's warranties.

Non-Emergency

Eye Examination: Charges for an eye examination performed by an Approved Provider.

Glasses (Lenses, Frames) and Contact Lenses: Charges for the following products and services are eligible when prescribed by an Approved Provider:

- corrective eyeglasses (frames and lenses) and contact lenses; and
- intraocular lenses used in cataract surgery

Annual Physical (Check-up): Charges for a visit to a licensed Physician for a general physical check-up, provided that the plan coverage period is a minimum of 6 months.

Birth-Control-Related Physician Visit: Charges for expenses incurred to visit a licensed Physician for reasons related to birth control. This benefit does not include the cost of any medication regardless of whether a prescription is required.

Acne-Related Physician Visit: Charges for expenses incurred to visit a licensed Physician for reasons related to a Participant's acne, whether for a new diagnosis or ongoing care for previously diagnosed acne. This benefit does not include the cost of any medication regardless of whether a prescription is required.

Attention Deficit Hyperactivity Disorder Treatment: Charges for expenses incurred to visit a licensed Physician, psychiatrist or psychologist related to a Participant's Attention Deficit Hyperactivity Disorder (ADHD), whether as a new diagnosis or ongoing care for previously diagnosed ADHD.

This coverage excludes the cost of any medication regardless of whether a prescription is required.

Durable Medical Equipment: Charges for rental of the following medical equipment:

- manual or electric wheelchair, including cushions and inserts; and
- manual or electric hospital bed, including mattress and safety side rails;
- equipment for the administration of oxygen, percussor, suction pump, bi-level positive air pressure (BiPAP), continuous positive airway pressure (CPAP) and ventilator;
- insulin pump for the Treatment of type 1 diabetes;
- compression pump, traction equipment; and
- patient lifter.

The purchase of durable medical equipment requires pre-approval from Blue Cross; otherwise it may be ineligible for payment in whole or in part.

If there is a long-term need for equipment due to extended illness or disability, Blue Cross may, at its discretion, approve the purchase of these items. If such purchase is approved, the rental or approved purchase of a second piece of similar equipment is limited to once every 5 consecutive calendar years.

Two pieces of equipment are similar if they serve the same purpose (for example, facilitate breathing, provide mobility, deliver insulin).

This coverage excludes charges for special mattresses and air conditioning or air purifying equipment.

Payment of Claims

How Payments are Made

The Participant will pay the full cost of any expense to the Approved Provider at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Certain Approved Providers may offer a pay direct arrangement. In such circumstances, the Approved Provider will submit the Participant's claim to Blue Cross electronically to verify eligibility at the time of purchase and the Participant will only pay the Approved Provider the portion of the claim that is not covered by this benefit. Blue Cross will reimburse the balance of the claim to the Approved Provider directly.

How Eligible Expenses are Calculated

Reimbursement of an Eligible Expense is calculated as follows:

Step 1. the Reimbursement Level percentage will be applied to the Eligible Expense; and
Step 2. the result is the amount payable by Blue Cross, subject to any Benefit Maximums applicable.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim at the earliest of the following:

- within 12 months of the date the Eligible Expense was incurred; or
- within 90 days after the date the Member's coverage is terminated.

Prescription Drugs

Additional Definitions

The following definitions apply to Prescription Drug benefits, in addition to those found under the *Key Terms* provision of this booklet.

Eligible Drug: A drug that is:

- approved by Health Canada;
- assigned a drug identification number (DIN);
- considered by Blue Cross to be a Life-Sustaining Drug or a drug that requires a prescription by law;
- prescribed by a physician or by a Health Practitioner who is licensed to prescribe under applicable provincial legislation;
- approved by Blue Cross as an Eligible Expense; and
- dispensed by an Approved Provider that is a licensed retail pharmacy or another provider that is approved by Blue Cross.

Blue Cross may, on an ongoing basis, add, delete or amend its list of Eligible Drugs.

Interchangeable Drug: An Eligible Drug that can be substituted for another Eligible Drug as both drugs:

- are considered pharmaceutical equivalents by Health Canada;
- contain the same active ingredients; and
- are administered in the same way.

Life-Sustaining Drug: An Eligible Drug that does not require a prescription by law but which Blue Cross is satisfied is necessary for the survival of the Participant. A prescription from a physician or Health Practitioner is still needed for reimbursement.

Medication Advisory Panel: The group of health care and other industry professionals appointed by Blue Cross to review new drugs and decide which drugs Blue Cross includes on its formularies.

Patient Support Program: A program that provides assistance and services to Participants when prescribed Specialty High Cost Drugs.

Specialty High Cost Drug: An Eligible Drug that requires Special Authorization and:

- is considered a Specialty High Cost Drug by the Medication Advisory Panel; or
- meets the following criteria:
  - costs $10,000 or more per treatment or per Policy Year;
  - is used to treat complex chronic or life threatening conditions such as cardiac, rheumatoid arthritis, cancer, multiple sclerosis or hepatitis c.; and
  - is prescribed by a specialist.

What Blue Cross Will Pay

Helpful Tip

To print a copy of our Special Authorization Prescription Drug Form, visit our website.

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment is limited to the reimbursement level and the benefit maximums specified in the Summary of Benefits;
- Blue Cross may determine that certain Eligible Drugs are subject to:
  - dollar, quantity or frequency maximums;
  - Special Authorization; or
  - co-ordination with Patient Support Programs;
- payment for a Specialty High Cost Drug may be reduced by the amount of financial assistance available under a Patient Support Program; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses listed below, provided they also meet the definition of Eligible Expenses contained under the *Key Terms* provision of this booklet:

- diabetic supplies, including test strips, lancets, needles, syringes, continuous glucose monitoring (CGM) sensors and insulin pump supplies;
- vaccines/immunizations recommended by a Canadian public health authority with jurisdiction where the Participant is residing in Canada (excludes injection service charges);
- glucose monitoring systems, including continuous glucose monitoring (CGM) receivers, transmitters or sensors for Participants prescribed insulin for the Treatment of diabetes
- managing chronic disease services, including initial assessment,
- preparations and compounds if their main ingredient is an Eligible Drug; and
- prescribed Eligible Drugs that appear on the following drug formulary:
  - **Open Formulary:** List of all Life-Sustaining Drugs and Eligible Drugs that require a prescription by law. This list is not subject to the Medication Advisory Panel decisions.

Helpful Tip

Your Student benefits plan provides you with access to most Eligible Drugs.

Certain Eligible Drugs require Special Authorization before your prescription is covered.

Special Authorization

Certain Eligible Drugs require prior or ongoing authorization by Blue Cross to qualify for reimbursement. The criteria to be met for Special Authorization are established by Blue Cross and may include requiring the Participant to participate in a Patient Support Program.

How does the Special Authorization process affect my claim?

The first time you present a prescription for an Eligible Drug on the Special Authorization list your pharmacist will indicate the need for Special Authorization.

You can request a Special Authorization Prescription Drug Form from your pharmacy, your plan administrator, the nearest Blue Cross customer information centre or from our website. You must complete the patient section of the form, have your physician complete and sign the remaining portion and mail your completed form to the nearest Blue Cross office.

Your request will be confidentially reviewed by a health care professional according to the payment criteria established. When all the required information is received by Blue Cross, the standard turn-around time for Special Authorization decisions is 7 to 10 working days.

You will receive confirmation in writing regarding the decision on your Special Authorization request. If your request is approved, this confirmation will include the effective date and duration of your approval.

Any fees associated with completing this form or obtaining additional medical information are your responsibility.

Plan Management Features

Substitution Provision

If the Summary of Benefits specifies Substitution Provision applies and an Interchangeable Drug has been prescribed, Blue Cross will reimburse to the lowest ingredient cost Interchangeable Drug. In the case of biologic drugs, Blue Cross reserves the right to reimburse to a less expensive biosimilar drug.

Participants may request a higher cost Interchangeable Drug; however, they will be responsible for paying the difference in cost between the Interchangeable Drugs.

Mandatory Generic Substitution:
Regardless of whether the Participant's physician indicates the prescribed Interchangeable Drug cannot be substituted, Blue Cross will only reimburse to the lowest ingredient cost Interchangeable Drug.

Helpful Tip

A generic drug and its brand name equivalent are considered to be Interchangeable Drugs. Health Canada imposes the same standards and tests on generic drugs as it does on brand name drugs. Generic drugs are effective and safe, while often being less expensive.

For Participants with an adverse reaction to the Interchangeable Drug dispensed, Blue Cross will consider reimbursement to another Interchangeable Drug on a case by case basis only through the Prior Authorization process.

Quebec Pharmacy Pricing Controls

If the Summary of Benefits specifies that Quebec pharmacy pricing controls apply, Participants will be responsible for paying the difference between the amount charged by the pharmacy for professional fees and the amount Blue Cross considers acceptable Usual, Customary and Reasonable charges.

Opioid Management

If the Summary of Benefits specifies that opioid management applies, certain Eligible Drugs will not be eligible for reimbursement, and other Eligible Drugs may require Prior Authorization. Opioid management ensures Participants are reimbursed for drugs with the best clinical evidence for pain management while managing the potential for overuse or misuse.

Payment of Prescription Drug Claims

How Payments are Made

The Summary of Benefits specifies the Method of Payment that applies to Participants under the plan.

Pay Direct: At the time of purchase, the Approved Provider will submit the Participant's claim to Blue Cross electronically to verify eligibility. The Participant will pay the Approved Provider only the portion of the claim that is not covered by this benefit. Blue Cross will reimburse the balance of the claim to the Approved Provider directly.

If the Participant submits to Blue Cross a paid-in-full prescription drug receipt, despite the fact pay direct was offered, Blue Cross will only reimburse the amount that would have been paid to the Approved Provider if the claim had been submitted electronically.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim at the earliest of the following:

- within 12 months of the date the Eligible Expense was incurred; or
- within 90 days after the date the Member's coverage is terminated.

Travel Outside Canada

Additional Definitions

The following definitions apply to Travel Outside Canada benefits, in addition to those found under the *Key Terms* provision of this booklet.

Emergency: A sudden and unexpected illness or injury occurring while the Participant is covered under the plan that requires immediate medical Treatment for acute pain or suffering which cannot be delayed until the Participant returns to their Home Country. Blue Cross will declare an end of Emergency upon determination that the Participant is fit to travel or return to their Home Country.

Hospital: A facility that:

- is licensed as an accredited hospital outside of Canada;
- 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 Blue Cross.

Immediate Family Member: A Participant's spouse, parents, child, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law or father-in law.

Trip: Travel outside of Canada.

What Blue Cross Will Pay

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

- payment is limited to the reimbursement level, benefit maximums and coverage duration specified below and in the Summary of Benefits;
- prior approval of Blue Cross 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 typically 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 Participant are, in the opinion of Blue Cross in consultation with its health care consultants, consistent with the frequency and quantity that would usually be prescribed or needed for the Participant'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, as specified under the *Coverage Details* section of this booklet); and
- payment is subject to post-payment audit.

Where a benefit appearing below is also listed under the Emergency Health Care benefits above, all benefit maximums are subject to, and combined with, the maximum amount stated there or in the *Summary of Benefits*.

Emergency Hospital and Medical Travel Coverage

Blue Cross will pay the Eligible Expenses listed in this section if:

- they are incurred as a result of an Emergency; and
- Blue Cross is satisfied the expense is necessary to stabilize the Participant's medical condition.

> **Helpful Tip**
> Make sure to bring your identification card with you when you travel.

Hospitalization: Charges for Hospital room accommodation (not a suite of rooms), emergency room fees and for Medically Necessary inpatient and outpatient services.

Psychiatric/Psychological Hospitalization: Room accommodation when a Participant is admitted to a Hospital due to psychological, mental or emotional disorders, suicide, any attempt at suicide, intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.

Coverage under this category also includes psychiatry services provided on an in-patient basis during the term of hospitalization under this benefit, as well as the cost of the initial Physician visit leading to this hospitalization.

Physician/Surgeon/Anaesthetist: Charges for the services of a qualified Physician, surgeon or anaesthetist who is not an Immediate Family Member of the Participant.

Durable Medical Equipment: Charges for rental of the following medical equipment:

- manual wheelchair, including cushions and inserts; and
- manual hospital bed, including mattress and safety side rails.

The accumulated charges for rental of any one of the above items must not exceed the standard market purchase price for the same item.

This coverage excludes charges for special mattresses.

Mobility Aids and Orthopedic Appliances: Charges for the rental of crutches, canes and walking aids, casts, splints, trusses and braces.

> **Helpful Tip**
> Before receiving nursing services you should obtain pre-approval from Blue Cross by contacting the toll-free number on your identification card.

Nursing Care: Charges for the services of a registered nurse, registered nursing assistant or licensed practical nurse where such services are provided at the Participant's home and are not primarily for custodial care or midwifery.

Nursing care services may require pre-approval from Blue Cross to be eligible for payment in whole or in part.

This coverage excludes expenses for custodial care, homemaking duties, shopping, transportation, respite care and services not related to the Activities of Daily Living.

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 on an outpatient basis following an initial covered Emergency or injury, not to exceed a 60 day supply per prescription. The Participant must provide satisfactory proof of purchase of this medication that includes:

- the name of the Participant;
- 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 required following an Emergency or injury. This coverage excludes charges for X-rays.

Accidental Dental and Other Dental Emergencies: Charges for:

a) dental Treatment when required to repair or replace a sound natural, or permanently attached artificial, tooth to a maximum of $4,000 per Policy Year. To be eligible for coverage, Treatment must be required as a result of a direct accidental blow to the mouth or a fractured or dislocated jaw that requires setting. A tooth is considered sound if, before the accident:

   - it was free from injury, disease or defect;
   - it did not need further restorations to remain intact or hold secure; and
   - it had no breakdown or loss of root structure or loss of bone, and

b) dental Treatment that is needed to relieve pain caused by an Emergency other than for the reason listed above, to a maximum of $1,000 per Policy Year; and

c) the extraction of impacted wisdom teeth to a maximum of $100 per tooth.

To be eligible for coverage, Treatment must be:

- incurred while covered for accidental dental benefits with the plan administrator;
- initiated within 7 days of the accident or dislocation or a detailed Treatment plan satisfactory to Blue Cross must be submitted for approval within that period; and
- performed within 90 days of the date of the accident or dislocation, unless the Participant has been approved by Blue Cross for deferred Treatment due to the Participant's age.

Helpful Tip

Coverage amounts are determined by the fee guide for dental general practitioners applicable to the dentist's province of practice in the year expenses are incurred.

This coverage excludes accidental damage to teeth that occurs while eating.

Ambulance Transportation: Charges for emergency transportation of a stretcher patient by a licensed ambulance to and from the nearest Hospital equipped to provide the emergency care needed by the Participant. This includes air or rail transportation, as well as taxi fare in lieu of ambulance transportation.

Transportation for Family to Visit the Participant: The cost of round-trip economy fare (by airline, bus or train) for up to 2 Immediate Family Members to the Hospital where the Participant has been confined for 7 or more days if the attending physician provides written acknowledgement that this attendance is required. Blue Cross may waive the 7 day waiting period if Blue Cross 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 Participant, if deceased.

The maximum reimbursement under this benefit is $5,000.

The cost of commercial living expenses for Immediate Family Members when using this benefit is also covered to a maximum reimbursement of $150 per Participant per day for a maximum of 10 days (up to a total maximum of $1,500 per incident).

All costs must be supported by receipts from commercial organizations.

Trauma Counselling: Charges for expenses incurred for trauma counselling commenced within 7 days and concluded within 90 days of an Emergency occurring during the Policy Year.

Worldwide Travel Assistance

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

Medical Assistance

If the Participant requires hospitalization or a consultation with a physician as a result of an Emergency, the travel assistance provider appointed by Blue Cross will provide the following support services:

- direct the Participant to an appropriate clinic or Hospital;
- confirm with the service provider that the Participant is covered;
- ensure a follow-up of the medical file and communicate with the Participant's family physician;
- co-ordinate the return home of a Child if the Participant is hospitalized;
- repatriation of the Participant to the province of residence if the Participant meets the eligibility requirements of this expense;
- arrange for the transportation of an Immediate Family Member to the Participant's bedside if the Participant meets the eligibility requirements of this expense; and
- co-ordinate the return of the Participant's vehicle if the Participant meets the eligibility requirements of this expense.

General Assistance

In Emergency situations, the travel assistance provider appointed by Blue Cross will also provide the Participant 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.

Blue Cross and its travel assistance provider are not responsible for the quality of medical and Hospital care provided to the Participant or for the availability of such care.

Payment of Travel Outside of Canada Claims

How Payments are Made

Blue Cross may approve payment directly to the service provider. In certain circumstances, the Participant will pay the full cost of any Eligible Expense at the time of purchase. Blue Cross will then reimburse any Eligible Expenses on receipt of proof of payment from the Participant.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the expense was incurred to be eligible for maximum reimbursement under the benefit.

In the event the Member's coverage is terminated, all claims must be submitted to Blue Cross within 90 days after the date coverage is terminated.

Exclusions and Limitations

Applicable to all Emergency Health Care Benefits

No payment will be made (or payment will be reduced) for:

a) any Illness, injury or medical condition that was not Stable in the 90 days prior to the Participant's coverage effective date;
b) health care covered under any government health care coverage or charges payable under any occupational health and safety board, automobile insurance bureau or other similar law or public plan;
c) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
d) services, treatment or supplies that the Participant receives free of charge;
e) charges that would not have been incurred if no coverage existed;
f) services, treatment or supplies provided by a Participant or an immediate family member of the Participant;
g) treatment or services within the Participant's Home Country after the Participant has permanently returned, or been repatriated, to their Home Country;
h) services, treatment or supplies that are:
    i. not incurred as a result of an Emergency;
    ii. not Medically Necessary;
    iii. for cosmetic purposes only;
    iv. elective in nature; or
    v. experimental or investigative.
i) all services relating to family planning, including artificial insemination, laboratory fees or other charges incurred in relation to infertility treatment, regardless of whether or not infertility is considered to be an illness;
j) services or supplies normally intended for recreation or sports;
k) 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
l) extra supplies that are spares or alternates;
m) translation services of any kind, even when utilized in the delivery of medical services;
n) organ transplants;
o) charges for missed appointments or the completion of forms;
p) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion;
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
    iii. an Illness or injury that occurred while under the influence of any intoxicants in contravention of any law, unless administered on, and in strict accordance with, the advice of a legally qualified Physician (this exclusion does not apply to substance abuse treatment benefit if covered under this plan);
    iv. an Illness or injury resulting from non-compliance with medical treatment or therapy that has been prescribed;
    v. suicide, attempted suicide or voluntary injury or illness. This exclusion applies to the following benefits if covered under this plan: air ambulance transportation, nursing care, tutorial service in Hospital, tuition reimbursement, other medical services and supplies, durable medical equipment, Health Practitioners (except mental Health Practitioners), mobility aids, orthopedic appliances and prostheses;
q) medical expenses incurred as a result of contracting COVID-19; except
    i) if the Participant contracted the illness after arrival in Canada;
    ii) had not been experiencing symptoms within 14 days of departure from the Home Country;
    iii) did not test positive within 14 days of departure; and
    iv) was not in contact with a confirmed case of COVID-19 within 14 days of departure; or
r) non-medical COVID-19 testing, such as for travel purposes.

Applicable to Prescription Drug Benefit Claims

Unless otherwise specified in the Summary of Benefits, expenses associated with the following categories of drugs are not eligible for reimbursement:

a) varicose vein injections;
b) smoking cessation aids;
c) vitamins;
d) weight loss treatments;
e) viscosupplementation injections;
f) natural health products, homeopathic and naturopathic products, herbal medicines and traditional medicines, nutritional and dietary supplements;
g) fertility treatments;
h) sexual dysfunction drugs;
i) all forms of cannabis; or
j) hair growth stimulants.

Helpful Tip

Direct2U is the preferred pharmacy for your prescription drugs.

For the same prescription, the price can vary depending on where you go, even among stores in the same chain.

Applicable to Travel Outside Canada Benefit Claims

No payment will be made (or payment may be reduced) if:

a) the Participant fails to communicate with Blue Cross in the event of medical consultation or hospitalization following an injury or illness;
b) expenses are incurred beyond the coverage duration period specified in the Summary of Benefits;
c) expenses incurred due to pregnancy or pregnancy complications that occur within 9 weeks of the expected date of delivery;
d) 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;
e) expenses have already been paid or are eligible for refund from a third party;
f) expenses for any care, treatment, surgery, products or services that could be delayed until the Participant's return to Canada;
g) 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
h) expenses are incurred as a result of suicide, attempted suicide or voluntary injury or illness.

Dental Benefit

Purpose of Coverage

Blue Cross will pay the Eligible Expenses described in this benefit, subject to the conditions outlined below.

> **Helpful Tip**
>
> Blue Cross limits its payments to the amount listed in the fee guide specified in the Summary of Benefits.
>
> Before starting your Treatment, ask your dentist if they follow the provincial fee guide.

Additional Definition

The following definition applies to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Unit: A 15 minute interval of time or any portion of a 15 minute interval of time.

Exception: When coverage is limited by Units but fees are not described in terms of Units by either:

- the fee guide in effect where Treatment is rendered; or
- the fee guide specified by this plan;

each incident of service is considered 1 Unit, regardless of its duration.

> **Helpful Tip**
>
> You are responsible for paying any expenses in excess of the fee guide listed in the Summary of Benefits. This is important to consider, since it can directly impact your out-of-pocket expenses.

What Blue Cross Will Pay

Blue Cross will pay Eligible Expenses subject to the following terms and conditions:

- payment of all Eligible Expenses is limited to the reimbursement level and benefit maximums specified below and in the Summary of Benefits;
- the Member must pay the Deductible, if any, specified in the Summary of Benefits;
- the amount of the Eligible Expense to which the reimbursement level applies is the lesser of:
  - the expense actually incurred by the Member; or
  - the fee amounts specified in the dental fee guide approved by Blue Cross (the applicable guide and annual edition are specified in the Summary of Benefits);
- the Eligible Expenses for laboratory fees are limited to 60% of the amount indicated in the provider fee guide for the dental service provided;
- if one or more forms of alternative Treatment exist, payment is limited to the cost of the least expensive Treatment that will meet the Participant's basic dental needs. This limitation applies to the benefits specified as Lowest Cost Alternative Benefit in the Summary of Benefits;
- Eligible Expense must have been performed by:
  - a licensed dentist;
  - a licensed denturist when the services are within the scope of their profession; or
  - a licensed dental hygienist under the supervision of a licensed dentist or independently where permitted by provincial legislation; and
- payment is limited in accordance with the Exclusions and Limitations provision of this benefit.

This benefit covers the expenses explicitly listed in the following categories, provided they also meet the definition of Eligible Expenses under the *Key Terms* provision of this booklet.

> **Helpful Tip**
>
> If a dental procedure is required as a result of an accident, it is considered as an extended health care expense rather than a dental benefit expense.

Preventive Care

Oral Examinations and Diagnosis: Charges for:

- complete or general oral examination to a combined maximum of 1 per 2 Policy Years;
- recall oral examination;

- emergency oral examination; and
- limited or specific oral examination to a combined maximum of 1 per Policy Year.

X-rays: Charges for:

- complete series to a maximum of 1 per 2 Policy Years;
- panoramic to a maximum of 1 per 2 Policy Years;
- intra-oral:
  - periapical;
  - occlusal and bitewings to a maximum of 1 procedure per Policy Year;
- sialography; and
- radiopaque dyes.

Laboratory Tests and Examinations: Charges for:

- bacterial culture;
- biopsy of soft oral tissue;
- biopsy of hard oral tissue; and
- cytological examination.

Preventive Treatment: Charges for:

- polishing of teeth;
- fluoride treatment;
- oral hygiene instruction to a maximum of 1 Unit per lifetime;
- pit and fissure sealants (limited to Participants under age 18);
- scaling; and
- space maintainers (limited to Participants under age 18).

Helpful Tip

Scaling refers to removal of plaque, calculus, and stains from teeth.

Basic Care

Restorations: Charges for:

- amalgam, acrylic, silicate or composite restorations on anterior and posterior teeth;
- retentive pins;
- pre-fabricated steel or plastic restorations; and
- pulp capping.

Helpful Tip

Restorations (fillings) refer to dental material used to restore the function and integrity of a tooth.

Oral Surgery: Charges for:

- removal of teeth and roots;
- surgical exposure and movement of teeth;
- surgical incision, excision and drainage of tumours or cysts;
- frenectomy (surgical alteration of the frenum);
- removal, reduction or remodelling of bone or gum tissue; and
- post-surgical care.

General adjunctive services: Charges for:

- anesthesia;
- temporary dressing for the emergency relief of pain; and
- finishing restorations.

Major Restoration

Extensive Restorations: Charges for:

- inlays;
- onlays; and
- crowns: for teeth damaged due to caries or traumatic injury (does not include pre-fabricated steel restorations).

Inlays, onlays and crowns are eligible to a combined maximum of 1 per tooth per 5 Policy Years.

Other Restorative Services: Charges for:

- cast post;
- prefabricated metal post;
- recementation of inlays, onlays or crowns; and
- removal of inlays, onlays or crowns.

Payment of Claims

How Payments are Made

At the time of purchase, the Approved Provider will either submit the Participant's claim to Blue Cross or provide a completed claim form and proof of payment to the Participant to submit to Blue Cross. The Participant will then be required to either:

- pay the portion of the claim that is not covered by this benefit and Blue Cross will reimburse the balance to the Approved Provider directly; or
- pay the total amount requested by the Approved Provider and the Participant will receive the portion of the expenses refundable by Blue Cross.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim within 12 months of the date the Eligible Expense was incurred.

Predetermination for Claims over $500

If the total cost of any Treatment is expected to exceed $500, the Member must submit to Blue Cross, before the Treatment begins, a detailed Treatment plan outlining the type of Treatment to be provided and the amounts to be charged.

Blue Cross will then notify the Member of the amount eligible for reimbursement. The Treatment must be performed by the dentist who prepared the Treatment plan; otherwise a new Treatment plan must be submitted to Blue Cross for re-assessment.

Date of Treatment

Eligible Expenses are considered to have been incurred on the date the service or supply was provided. For procedures requiring more than 1 appointment, the Eligible Expense is considered to have been incurred on the date that the entire procedure was completed or the appliance was placed.

Exclusions and Limitations

Unless otherwise specified in the Summary of Benefits, no payment will be made (or payment will be reduced) for:

a) services, treatment, articles or supplies that do not fall within the categories of Eligible Expenses listed in this benefit;
b) services, treatment or supplies covered by any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan;
c) dental care that was covered under any government health care coverage or charges payable under a workers' compensation board/commission, automobile insurance bureau or other similar law or public plan, when this benefit was issued but has since been modified, suspended or discontinued;
d) services, treatment or supplies the Participant receives free of charge;
e) charges that would not have been made if no coverage had existed;
f) anti-snoring or sleep apnea devices;
g) services rendered by a dental hygienist but not administered under the supervision of a dentist, except in provinces where such supervision is not legally required;
h) services, treatment or supplies that are:
    i. not Medically Necessary (except for Preventive Care services);
    ii. for cosmetic purposes only; or
    iii. experimental or investigative;
i) services or expenses incurred as a result of:
    i. insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion; or
    ii. participation in a criminal act or attempt to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
j) expenses incurred after the termination date of the Participant's coverage, even if a detailed treatment plan was submitted and accepted by Blue Cross before this date;
k) services that are eligible under the extended health care, if applicable (except for extraction of impacted wisdom teeth);
l) splinting for periodontal reasons, where cast crowns, inlays or onlays are used for this purpose;
m) treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension or TMJ (temporomandibular joint)/myofascial pain dysfunction;
n) veneers;
o) implants and related services;
p) extra supplies that are spares or alternates; or
q) charges for missed appointments or for the completion of forms.

Member Accidental Death and Dismemberment Benefit

Purpose of Coverage

If, as a result of an Accident, the Member dies or suffers a Loss defined in this benefit, Blue Cross will pay the amount shown in the Summary of Benefits, subject to the conditions outlined below.

Additional Definitions

The following definitions apply to this benefit, in addition to those found under the *Key Terms* provision of this booklet.

Common Carrier Loss: Any loss specified in the Table of Benefits that is the result of an injury sustained while riding as a fare-paying passenger on a Common Carrier.

Loss: Any loss specified in the Table of Benefits.

Loss of arm: Complete severance at or above the elbow joint.

Loss of foot: Complete severance at or above the ankle joint but below the knee joint.

Loss of hand: Complete severance at or above the wrist joint but below the elbow joint.

Loss of leg: Complete severance at or above the knee joint.

Loss of sight: Total and irrecoverable loss of sight, certified by a physician.

Coverage

To be covered under this benefit, a Loss must:

- result from an Accident that occurs while the Member is covered under this benefit; and
- occur within 365 days after the date of this Accident.

A Member will also be considered to have suffered loss of life as a result of an Accident if the Member's death is due to accidental drowning.

Disappearance

A Member will be deemed to have suffered loss of life as a result of an Accident if their body is not found within 365 days (unless there is contrary evidence to suggest that the Member is still alive).

Rehabilitation

If benefits are payable to a Member as a result of a Loss, Blue Cross will pay reasonable and necessary expenses incurred by the Member for special training, provided that:

- these expenses are incurred within 3 years of the date of the Accident; and
- the training is needed:
  - as a result of the Loss; or
  - to enable the Member to work in an occupation for which they were not qualified before the Loss.

The amount payable under this benefit provision will not exceed a lifetime maximum of $5,000.

This coverage excludes travel, clothing and ordinary living expenses.

What Blue Cross Will Pay

In the event of Loss, Blue Cross will pay the following coverage amounts:

Table of Benefits

Loss of	Amount of coverage
Life	$10,000
Two or more limbs*	$10,000
Sight in both eyes	$10,000
Sight in one eye and one limb*	$10,000
One limb*	$5,000
Sight in one eye	$5,000

***Limb:** arm, foot, hand or leg.

Payment of Claims

Beneficiary

In the case of loss of life, Blue Cross will pay benefits directly to the Member's beneficiary, unless otherwise specified in this benefit. For any other Loss, benefits will be paid to the Member.

Maximum Amount Payable

The total amount payable for one or more Losses that results from the same Accident will not exceed 100% of the amount of coverage specified in the Summary of Benefits.

Blue Cross will only pay one amount, the largest applicable, for injuries to the same limb that result from the same Accident.

Time Limit to Submit a Claim

Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 6 months following the date of the loss. If coverage has terminated, proof of claim must be received no later than 90 days following the date of the loss.

Exclusions and Limitations

Blue Cross will not pay any benefits for a Loss that results directly or indirectly from the following causes:

a) natural causes;
b) any medical or surgical treatment or illness or disease of any kind, other than septic infection caused through a wound sustained as a result of an Accident;
c) suicide, attempted suicide or voluntary injury or illness;
d) voluntary ingestion of poison or drugs;
e) inhalation of fumes, unless an occupational health and safety board has deemed such inhalation to be an Accident;
f) any Accident or injury occurring while the Member is participating in a criminal act or attempting to commit a criminal act, regardless of whether charges are laid or a conviction is obtained;
g) insurrection, war (declared or not), the hostile action of the armed forces of any country or the Member's participation in any riot or civil commotion;
h) injuries sustained while the Member is flying or attempting to fly an airplane or other type of aircraft, if the Member is part of the crew or is performing any other flight duties; or
i) any Accident or injury that occurs while the Member is operating a vehicle under the influence of any intoxicant or with a blood alcohol level in excess of the legal limit in the jurisdiction in which the Accident occurred.

You and Your Dependents

Throughout this booklet several key terms are used to refer to you and your Dependents:

- the terms that may refer to you are: International Student, Teacher, Chaperone, Member and Participant;
- the terms that may refer to your Dependents are: Dependent, Spouse, Child and Participant.

International Student: A person

- who temporarily resides in Canada; and
- is enrolled at and attending a Participating Educational Institution.

Member: An International Student, Teacher or Chaperone who is eligible and approved for coverage under this policy.

Dependent: Your Spouse or Child.

Spouse: The person who:

- temporarily resides in Canada; and
- meets one of the following criteria:
  - is married to the Member; or
  - has been living with the Member in a conjugal relationship for at least 1 year; however, where required by provincial legislation, this 1 year period is waived if a child is born of such relationship.

Helpful Tip

You are responsible for enrolling your Dependents under the plan when they become eligible.

In addition, you are responsible for removing them when they no longer meet the definitions outlined here.

You can update your family or Dependent status by filling out and submitting a change form, available through our website.

The Spouse must be designated by the Member on their application for coverage. Only one person may be covered as a Spouse at any one time.

Child: A person who:

- temporarily resides in Canada;
- is the natural or adopted child of the Member or Spouse, or the child over whom the Member or Spouse has been appointed as guardian with parental authority;
- is financially reliant on the Member or Spouse for care, maintenance and support;
- is not married or in a common law relationship; and
- meets one of the following criteria:
  a) is at least 15 days old, unless born as a result of a Participant's pregnancy commenced while covered under this policy, and under age 21;
  b) is under age 26 and is attending an accredited educational institution, college or university on a full-time basis; or
  c) became mentally or physically disabled while a child as defined in (a) or (b) and has been continuously disabled since that time.

Helpful Tip

A Member, Spouse and Child are all Participants under the policy.

A child is considered to be mentally or physically disabled for the purposes of this definition if they are incapable of engaging in any substantially gainful activity and are financially reliant on the Member or Spouse for care, maintenance and support due to this disability. Blue Cross may require the provision of written proof of a child's disability as often as is reasonably necessary.

Participant: The Member or one of the Member's Dependents who has been approved for coverage under this policy.

Other Important Terms

Accident: A sudden, fortuitous and unforeseeable event that:

- is violent in nature;
- arises solely from external means;

- causes bodily injury to the Participant directly and independently of all other causes; and
- is unintended by the Participant.

The resulting injury to the Participant must be certified by a physician.

Approved Provider: A provider of health care services or supplies who has been approved by Blue Cross to provide specific Eligible Expenses.

Chaperone: A person who is visiting Canada temporarily for the purposes of accompanying one or more International Students while monitoring their behaviour and ensuring their safety at a Participating Educational Institution.

Common Carrier: A person or organization that commercially offers transportation services to fare-paying passengers by land, water or air vehicles on a for-profit basis.

Eligible Expenses: Charges incurred by the Participant for health care services and supplies that are:

- Medically Necessary;
- recommended or prescribed by a Physician or Health Practitioner who:
  - does not normally reside in the Participant's home;
  - is not the Participant's Family Member; and
  - is not the Participant's plan administrator or co-worker;
- rendered or dispensed by an Approved Provider who:
  - does not normally reside in the Participant's home; and
  - is not the Participant's Family Member; and
- rendered or dispensed after the effective date and while the policy is in effect, unless otherwise specified.

Helpful Tip

Important: Blue Cross will only reimburse health expenses meeting these Eligible Expenses criteria.

Health care services and supplies that Participants prescribe, render or dispense to themselves are not Eligible Expenses.

An Eligible Expense is considered to be incurred on the date the service or supply was received by the Participant.

Where more than one form or an alternative form of Treatment exists, Blue Cross has the right to base its payment for Eligible Expenses on the lowest cost alternative if Blue Cross, in consultation with its health care consultants, deems the alternative Treatment to be appropriate and consistent with good health management.

Emergency: A sudden and unexpected illness or injury occurring while the Participant is covered under the plan that requires immediate medical Treatment for acute pain or suffering which cannot be delayed until the Participant returns to their Home Country. Blue Cross will declare an end of Emergency upon determination that the Participant is fit to travel or return to their Home Country.

Health Practitioner: A health care practitioner who is a registered member of their regulatory body (if applicable) and practices within the limits of their authority as established by law. If no occupational guild applies to a particular practitioner, the practitioner must:

- be a registered member of their association;
- provide care and treatment within the limits of their professional scope of practice; and
- be an Approved Provider.

Home Country: The country in which the Participant maintained permanent residence prior to arrival in Canada.

Hospitalization: Admission to a hospital as an inpatient for a minimum period of 24 hours that occurs upon recommendation of a physician as being Medically Necessary.

Illness: A sudden and unforeseeable deterioration of health or a bodily disorder that has been diagnosed by a Physician and requires regular and continuous care.

Life Event: A situation resulting from one of the following that permits a Member to change their coverage:

- marriage or common law union;
- birth or adoption of a child;
- divorce or legal separation;
- the Member's or Dependent's other coverage terminates for reasons outside of their control; or
- death of a Dependent.

Medically Necessary: A health care service or supply provided or prescribed by a Physician or Health Practitioner to treat an injury or Illness that, in the opinion of Blue Cross after consultation with its health care consultants:

- has not been provided or prescribed primarily for convenience or cosmetic reasons;
- is the most appropriate, safe and cost effective Treatment for the diagnosed injury or Illness; and
- is generally medically recognized as acceptable Treatment for the diagnosed injury or Illness.

Helpful Tip

Blue Cross will only pay for Eligible Expenses that are Medically Necessary.

Participating Educational Institution: An accredited educational institution, college or university in Canada that has agreed to participate in this plan.

Policy Period: The period of time, not to exceed the Policy Year, beginning on the first day of a Participant's enrolment period and ending on the last day of the enrolment period as provided by the plan administrator.

Policy Year: The period of time beginning on the first day of September in a given year and ending on the last day of August the following year.

Stable: A state of being in which the Participant has an existing medical condition for which they, in the 90 days before the Policy Year begins, have 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).

Teacher: A person in the education profession who:

- is visiting Canada temporarily for the purposes of accompanying one or more International Students; or
- is visiting under the sponsorship of a Participating Educational Institution as part of a cultural exchange or similar program.

Treatment: The management and care of a Participant to improve or cure an Illness, disorder or injury. This management and care must be:

- considered appropriate and approved by Blue Cross; and
- prescribed, provided or performed by a Health Practitioner or Physician practicing in the field of medicine applicable to the Participant's disease, disorder or injury.

Who is Eligible for Coverage?

You are eligible for coverage if you:

- meet the definition of International Student, Teacher or Chaperone;
- spend at least 51% of the Policy Year in Canada;
- are not eligible for government health care coverage; and
- are under age 65.

Your Dependents are also eligible for coverage if they meet the definition of Spouse or Child outlined above in the *Key Terms*.

How do I Enrol for Coverage?

You are automatically enrolled for coverage under this plan by your educational institution.

Can I Opt Out of Coverage for Certain Benefits?

You are not allowed to individually select the benefits you want under the policy.

When Does My Coverage Begin?

International Students, Teachers or Chaperones

Your coverage takes effect on the latest of the following dates:

- the date your plan administrator confirms you are covered under this policy;
- the date you leave your Home Country to come to Canada;*
- the effective date shown on your confirmation of coverage letter; or
- the date you meet all of the eligibility requirements.

*Travel from your Home Country to Canada is covered provided that the total trip length between departure from your Home Country and arrival in Canada does not exceed 7 days.

Early Arrival Coverage

If you are applying for coverage under this policy for the first time and you arrive in Canada prior to the start of the Policy Year, coverage for you and your eligible Dependents takes effect the latest of the following dates:

- the date you arrive in Canada; or
- the first of the month immediately preceding the start date of your attendance at the Participating Educational Institution.

Dependents

Your Dependent's coverage takes effect on the latest of the following dates:

- the date you become eligible for coverage;
- the date they meet all of the eligibility requirements; or
- the date following their discharge from hospital if they were hospitalized on the date they would have become eligible for coverage, unless:
  - they were covered under a Previous Policy, in which case their coverage begins on the effective date of the policy; or
  - they were born while this coverage is in force, in which case their coverage will be effective from the date on which they meet the definition of Child under this policy.

Helpful Tip

Previous Policy refers to a group insurance policy that provided coverage for you and your Dependents, and terminated within 31 days of the effective date of this Student plan.

When Does My Coverage End?

Coverage ends on the earliest of the date:

- the policy terminates;
- you reach age 65;
- you reach the termination date, if any, specified in the Summary of Benefits;
- you die;
- your coverage expires as indicated in your confirmation of coverage letter;
- you return to your Home Country permanently;
- that reasonable evidence of fraudulent activity of this policy is obtained;
- 60 days after you are no longer enrolled and not attending a participating educational institution; or
- 60 days after you or your Dependents no longer meet one or more of the eligibility requirements.

Coverage for your Dependents will also terminate on the date your coverage terminates.

No coverage will be provided to you or your Dependents while performing duties as an active member in the armed forces of any country, unless coverage must be retained under applicable provincial legislation.

Extension of Coverage After Termination

If you are hospitalized on the last day of the policy's coverage period for an eligible Illness or injury, coverage will automatically be extended for an additional 30 days without additional premium. Coverage for the same Illness or injury for which you were initially hospitalized will be extended for an additional 72 hours after being discharged from the hospital to facilitate a return to your Home Country.

Coverage is automatically extended for up to 72 hours in the event you miss your scheduled return to your Home Country due to a delay caused by the Common Carrier with which you are a passenger.

What if I Have Coverage Elsewhere?

Blue Cross will co-ordinate your Student benefits coverage with other health plans when similar coverage is available. The co-ordination of benefits process helps ensure you get the most out of your coverage. It means you can receive up to, but no more than, 100% reimbursement for Eligible Expenses.

Other Health Plans

Do you take advantage of coverage under the other benefit plans available to you, such as your Spouse's? If not, you may be missing out on possible reimbursement of up to 100% of Eligible Expenses.

Blue Cross applies co-ordination of benefits according to the guidelines of the Canadian Life and Health Insurance Association Inc. (CLHIA). Here are the general rules:

Expenses for Yourself:

- You must first submit expenses incurred to this plan (where you are covered as a Member). The balance that has not been paid by this plan (if any) can then be submitted to the other plan where you are covered as a dependent (for example your Spouse's plan).
- If you are covered as a member under more than one group benefit plan, the plan that has covered you the longest pays first.

Helpful Tip

The types of other plans that are potentially subject to co-ordination of benefits include any form of group, individual, family, creditor or saving insurance coverage that provides reimbursement for medical treatment, services or supplies.

Expenses for Your Spouse:

- Your Spouse must submit any expenses incurred for themselves to their own group benefit plan (if any) first. The balance that is not paid by their plan (if any) can then be submitted to this plan.

Helpful Tip

For more information on co-ordination of benefits (including examples), visit our website.

Expenses for Your Child:

- If a Child is covered as a dependent by both you and your Spouse, you should submit their claim to the plan of the parent whose birthday comes first in the year.
- In the event of divorce or separation, the plan of the parent with whom the Child resides (the plan of the parent with custody of the Child) pays first.

What Are My Responsibilities Under the Policy?

Keeping Your Student Plan Administrator Informed

To ensure coverage is kept up-to-date for you and your Dependents, it is important to report any changes to your Student plan administrator within 31 days of the change. Failure to do so could result in the need for proof of health before your requested change in coverage takes place.
Changes that must be reported to your Student plan administrator include:

- Adding or removing a Dependent
- Status updates of a Dependent student
- Change in marital status
- Change of beneficiary
- Application for benefits previously waived

Helpful Tip

It is very important to maintain up-to-date beneficiary designations.

When insurance money is paid to the estate, it may be subject to creditor claims and estate taxes.

However, when a beneficiary is named, this person receives the entire benefit tax free, regardless of what debts may be owed by the deceased.

You can change your beneficiary by filling out a beneficiary designation form available through your Student plan administrator or on our website.

Beneficiary Designations

Unless otherwise designated, all benefits are payable to you.

Death Benefits

Benefits payable as a result of your death will be paid to your last designated beneficiary or beneficiaries.

Subject to the provisions of the law, the beneficiary is the person you have designated on your Student benefits application form, if applicable. You may change your beneficiary by submitting a signed written declaration to Blue Cross.

If you designate 2 or more beneficiaries (other than alternatively) without any specification as to how the death benefit will be divided, the benefit payable will be divided equally among the designated beneficiaries.

If your beneficiary predeceases you, you must designate a new beneficiary.

If you die and a beneficiary has not been named in writing, the death benefit will be payable to your estate.

Providing Proof of Claim

You must submit your claims for Eligible Expenses within applicable time limitations. Proof of claim must be provided in writing and in a form acceptable by Blue Cross.

Blue Cross must approve your proof of claim and may require you to provide additional information and undergo a medical examination by a physician or Health Practitioner as often as deemed necessary. Blue Cross reserves the right to suspend or deny a claim until you have submitted the additional information requested to process the claim.

Costs associated with providing proof of claim are your responsibility.

Submitting Claims After Your Student Plan Terminates

If the Student plan has terminated, you must submit proof of claim to Blue Cross **within 90 days** following the termination date of this plan for all benefits.

Recovering Damages From a Third Party (Subrogation)

If you have the right to file legal action against a third party (individual or corporate body) for a loss relating to any claim submitted under this Student benefits plan, Blue Cross is entitled to acquire your rights for recovering damages for any portion of the loss that has been paid by Blue Cross.

You must sign and return the necessary documents to facilitate this process and you must do everything that is required of you to protect your rights to recover damages from the third party.

Reporting Health Insurance Fraud

Health insurance fraud is the intentional act of submitting false, deceiving or misleading information for the purpose of financial gain.

Whether committed on a small or large scale, fraud can lead to significant financial losses to the benefit plan and result in higher premiums and decreased coverage. Blue Cross is committed to protecting the integrity of our benefit programs for our policyholders and members by monitoring and resolving any abusive or fraudulent activity.

Helpful Tip

Health care fraud in Canada is estimated to cost between $2 billion and $12 billion annually.

How You Can Help

As a Student plan member, you can help eliminate fraudulent abuse of your plan:

- keep your identification card, policy number, member identification number and related information confidential and secure;
- carefully review your receipts for products and services claimed to ensure:
  - you understand the charges billed; and
  - the charges reflect the services received.

If you are unclear about any of the charges on your receipt, ask your provider to explain the charges to you:

- carefully review your Explanation of Benefits claim statements (EOB) for any discrepancies in services received compared to services claimed;
- never sign a blank claim form;
- from time to time, we send member verification questionnaires to confirm treatments and other related information. If you receive one of these questionnaires, please complete it and return it promptly. These questionnaires are essential to our fraud deterrence efforts.

Helpful Tip

If you suspect health care fraud, please refer it to Blue Cross through one of the following confidential methods:

Toll free: 1-877-412-8809

StopFraud@medavie.bluecross.ca

www.medavie.bluecross.confidenceline.net

What Are My Rights Under the Policy?

Privacy

In the course of providing customers with quality life, health and travel coverage, Blue Cross acquires and stores certain personal information about its clients and their dependents.

Protecting the confidentiality of client information is fundamental to the way we do business. Our staff takes our privacy policies and procedures very seriously.

What is personal information?

Personal information includes details about an identifiable individual and may include name, age, identification numbers, income, employment data, marital and dependent status, medical records, and financial information.

How is Your Personal Information Used?

Your personal information is necessary for Blue Cross to process your application for coverage under its life, health and travel plans. Your personal information is used to provide the services outlined in your benefit plan, to understand your needs so that we can recommend suitable products and services, and to manage our business.

To Whom Could This Personal Information be Disclosed?

Helpful Tip

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

Depending on the type of coverage you carry, release of selected personal information to the following may be necessary in order to provide the services outlined in the benefit plan of which you are an eligible member:

- specialized health care professionals when required to assess benefit eligibility;
- government and regulatory authorities in an emergency situation or where required by law ;
- Blue Cross Life Insurance Company of Canada and other third parties, on a confidential basis, when required to administer your benefits; or
- the plan member in any contract under which you are a participant.

We do not provide or sell personal information about you to any outside company for use in marketing and solicitation. Personal information about you or your Dependents is not released to a third party without permission unless necessary to fulfil the services Blue Cross is contracted to provide to you.

By becoming a Blue Cross customer or filing a claim for benefits, you are agreeing to allow your personal information to be used and disclosed in the manner outlined above.

Disputing a Claim Decision

In the event Blue Cross determines that benefits are not payable, you have the right to appeal the decision by providing written notice to Blue Cross within 30 days from the date of the written denial.

The time limitation to bring an action against Blue Cross under the benefit plan begins on the date of the initial written denial from Blue Cross and runs until the expiry of the minimum limitation period as prescribed by the applicable provincial legislation.

Every action or proceeding against Blue Cross for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

Copy of the Benefit Plan

Where legislated, you have the right to request a copy of the contract for insured benefits, your application for benefits and any written statements or other record provided to Blue Cross as proof of your health.

The Rights of Blue Cross Under the Policy

Right to Audit

Blue Cross has the right, at any time, to inspect or audit the health and claim records of a Participant in relation to a claim for benefits.

Helpful Tip

The right to inspect or audit applies to records held by Blue Cross or Approved Providers.

Recovery of Overpaid Amounts

Blue Cross has the right to recover from a Participant:

- any amount paid in error;
- any amount paid as a result of claims made by the Participant on the basis of fraudulent pretences or misrepresentations; or
- any amount paid that has resulted in overpayment to the Participant.

Blue Cross has the right to reduce future benefit payments to the Participant until the excess amount is fully recovered.

Termination or Suspension of Benefit Payments

Blue Cross may, without prior notice, suspend or terminate the rights and benefits of a Participant in the following circumstances:

- the discovery of a claims discrepancy or the initiation of a claim abuse investigation; or
- the filing of criminal charges or initiation of disciplinary action against the Participant by Blue Cross.

Blue Cross also has the right to suspend or deny payment of a claim for any services or supplies prescribed, rendered or dispensed by a provider who is under investigation by a regulatory body or by Blue Cross or who has been charged with an offence in relation to the provider's conduct or practice.

How to Obtain a Claim Form

Health benefit claim forms can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- your Student benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.

All claim forms for accidental death and dismemberment benefits can be obtained through your Student benefits administrator.

How to Submit a Claim

If you have paid up front for medical services, you must submit your claim for reimbursement. To submit a claim, go online to **studentvip.ca** or contact the appropriate campus Health Plan Office (see Additional Resources and Information section for contact details).

Blue Cross also offers convenient options to quickly and efficiently submit your health benefit claims:

- **Provider eClaims**
  For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your Student benefits plan (if any).

- You can also mail your completed claim form to the nearest Blue Cross office.

Helpful Tip

Instead of a cheque by mail, get reimbursement directly to your bank account by signing up for direct deposit. It's fast, and convenient. Visit our website to register.

You can submit your claims for **accidental death and dismemberment benefits** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form;
- dropping the form off at one of our Quick Pay locations; or
- providing them to your Student benefits administrator.

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- **Coverage inquiry:** Detailed information about your Student benefits plan;
- **Forms:** Printable versions of Blue Cross forms;
- **Addition/updating of banking information** for direct deposit of claim payments;
- **Member statements:** view claims history for you and your Dependents;
- **Record of payments:** view transactions issued to yourself or the service provider.

To register for the plan member website, visit **www.medavie.bluecross.ca** and log in.

Helpful Tip

For security reasons, the plan member website is for your use only. Dependents and other family members will not have access to the site.

Helpful Tip

Please record your user ID and password in a secure site for future reference.

Blue Cross Contact Information

For more information about your Student benefits coverage or the plan member website, please contact our Customer Information Contact Centre toll free at:

From Anywhere in Canada: 1-833-867-3468

Helpful Tip

Have your Student plan number and identification number ready when you call for questions regarding your coverage.

Connect with Blue Cross

Like us on Facebook at **facebook.com/MedavieBlueCross**

Follow us on Twitter at **@MedavieBC**

My Good Health®

My Good Health is a secure, interactive web portal that provides valuable health information and tools for managing your health. You can create your own health profile and use it to map personal goals using My Good Health resources.

Blue Cross is proud to help point your way to healthier living. Go to **medaviebc.mygoodhealth.ca** and simply follow the instructions to register for your free account!

BLUE ADVANTAGE®

Savings are available to Blue Cross Members across Canada. To take advantage of these savings, simply present your identification card to any participating provider and mention the **Blue Advantage®** program. A complete list of providers and discounts is available at **www.blueadvantage.ca.**

Additional Resources with your Student Benefits Administrator

Student VIP
info@studentvip.ca
cheryl@studentvip.ca
1-888-918-5056

Live Chat with a Student VIP Specialist at **www.studentvip.ca/scc**