SUMMARY of COVERAGE

Student Health Insurance Plan

VHiP

Administered by Excel Pacific Financial Inc

09/04

Visa Student Health Insurance Plan (VHIP) is administered by Excel Pacific Financial Inc. The insurance company under contract with VHIP to underwrite VHIP benefits and provide claims services is Industrial-Alliance *Pacific* Life Insurance Company (hereinafter called the Company). The Company hereby agrees to insure all eligible full-time students (herein individually called the Insured Person), whose names are on file with the Policyholder and for whom the applicable premium has been paid and are in good health on the effective date of the policy and have passed all medical requirements to enter Canada for the benefits hereinafter described for loss resulting independently of all other causes from Injury or Sickness.

DEFINITIONS

"Chronic Condition" means a disease or disorder which has existed for a minimum of six months.

"Emergency" means an event that makes it necessary to receive immediate treatment from a Physician or be immediately hospitalized.

"Hospital" means an institution operated pursuant to law for the care and treatment of sick and injured persons with organized facilities for diagnosis, major surgery and 24 hour nursing service. This does not include a convalescent or nursing home, or home for the aged, health spa or a facility for the treatment of alcoholism, drug addiction or mental illness.

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

"Insured Person" means an eligible full-time non Canadian student, under age 70, who (a) holds an International Student Visa; (b) is under the administration of the Policyholder, (c) resides in Canada, (d) does not qualify for any Canadian federal and/or provincial health and hospitalization insurance plan, and (e) is registered in and attending classes at a recognized institution of learning within Canada on the effective date of their coverage.

"Member of the Immediate Family" means a person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the above include natural, adopted or step relationships), spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person who are living with the Insured Person in Canada.

"Nurse" means a graduate registered nurse (R.N.) or nurse who is licensed to practise nursing by a governmental agency having jurisdiction over such licensing, provided such nurse is neither the Insured Person himself nor a Member of the Immediate Family.

"Physician" means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practise medicine by 1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing organization, or 2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

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

"Residence" means the primary dwelling in Canada of which the Insured Person is an occupant and the premises on which it is situated.

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

"Stabilized" means that there has not been a change in the medical condition requiring medical or psychiatric intervention for a minimum of six months.

Whenever a reference to the masculine gender appears in the policy, it will also be construed to include the feminine gender.

MEDICAL REIMBURSEMENT EXPENSES

A. When by reason of Injury or Sickness, an Insured Person requires medical or surgical treatment and incurs eligible expenses as described in this part, the Company will reimburse the reasonable and necessary charges for services or supplies received by the Insured Person in accordance with the following:

(a) Hospital charges for room and board, subject to the daily standard ward accommodation rate currently charged by the Hospital in the province or territory of Residence. Drugs prescribed and administered by the attending Physician while in Hospital are covered. Hospitalization for any condition related to the Human Immunodeficiency Virus (HIV) is not covered if the Insured Person's positive HIV test was known by anyone prior to the effective date of insurance, otherwise, coverage is limited to a one-time hospitalization maximum of 72 hours;

(b) Hospital charges for out-patient services in the province or territory of Residence when medically required;

(c) expenses of a Nurse who does not ordinarily reside in the Insured Person's Residence, when recommended by a Physician, subject to a maximum of $500.00 per policy year;

(d) expenses charged by a licensed professional physiotherapist for physiotherapy treatment ordered or prescribed by a Physician, provided such physiotherapist does not ordinarily reside in the Insured Person's Residence and is not a Member of the Immediate Family, subject to a maximum of $500.00 per policy year;

(e) expenses incurred for blood plasma, whole blood or oxygen, including the administration thereof;

(f) expenses incurred for x-rays and laboratory examinations which are required for diagnostic purposes;

(g) expenses for medical care and treatment rendered or surgical procedure performed by a Physician, subject to the health insurance plan schedule of fees published by the province or territory of the Insured Person's Residence;

(h) expenses for the services of a licensed anaesthetist when recommended by a Physician, subject to the health insurance plan schedule of fees published by the province or territory of the Insured Person's Residence;

(i) expenses for the services of any of the following licensed practitioners, provided such practitioner does not ordinarily reside in the Insured

Person's Residence and is not a Member of the Immediate Family, subject to a maximum of $500.00 per speciality per policy year (such services do not require the recommendation of a Physician except as indicated: (i) chiropractor; (ii) osteopath; (iii) chiropodist; (iv) podiatrist; (v) massage therapist; on the recommendation of a Physician; (vi) speech therapist; (vii) psychologist. Expenses for diagnostic x-rays and laboratory tests ordered by a chiropractor, osteopath, chiropodist or podiatrist will be allowed as expenses under the services of such practitioners, subject to a maximum of one x-ray per practitioner for each Insured Person in any one policy year;

(j) expenses for specific dental procedures if performed in an operating room by a dental surgeon appointed to the dental staff of the Hospital.

B. The Company will also reimburse the reasonable and necessary charges for services or supplies received by the Insured Person in accordance with the following:

(a) expenses for an annual health examination;

(b) expenses for eye examination by a licensed ophthalmologist or optometrist to determine if purchase or replacement of eyeglasses or contact lenses are required, subject to not more than one examination every one policy year for Insured Persons under 19 years of age and one examination every two consecutive policy years for Insured Persons 19 years of age and over;

(c) artificial limbs, eyes or other permanent prosthetic appliances;

(d) rental of a wheelchair, iron lung and other durable equipment for therapeutic treatment, not to exceed the purchase price prevailing at the time rental became necessary;

(e) orthopedic shoes if part of a brace, including any fee charged by a Physician, subject to a maximum of $200.00, for designing, constructing, fitting or applying such device; charges for orthopedic shoes are limited to $100.00 per pair and to a maximum of one pair per Insured Person per policy year;

(f) miscellaneous expenses for hearing aids, crutches, splints, casts, trusses and braces, but not including replacement thereof; braces do not include dental braces and are subject to a maximum of $750.00 during any one policy year.

Pre-Authorization

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

ACCIDENTAL DENTAL REIMBURSEMENT BENEFIT

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

DENTAL TREATMENT BENEFIT

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

AMBULANCE EXPENSE

Expenses for a licensed ground ambulance service are covered or ,when recommended by a Physician, for any other conveyance, other than air ambulance, licensed to carry passengers for hire to or from the nearest Hospital which is equipped to provide the required treatment, subject to a maximum of $100.00 per Injury or Sickness. Expenses for a licensed air ambulance are covered, subject to prior approval from the provincial emergency health services and to the maximum specified in the health insurance plan schedule of fees published by the province or territory of the Insured Person's Residence.

PRESCRIPTION DRUG REIMBURSEMENT

When, by reason of Injury or Sickness, an Insured Person incurs expenses for prescription drugs or medicines prescribed in writing by a Physician, the Company will reimburse the actual cost of such prescription drugs or medicines, subject to a maximum of $500.00 per Insured Person per policy year. Drugs or medicines must be prescribed and purchased for use during the term of insurance, subject to a dispensing maximum of a three-month supply. The following expenses are excluded: (a) oral contraceptives; (b) fertility drugs; (c) male pattern baldness remedies; (d) smoke cessation or anti-smoke remedies, including nicorette gum, patches or similar products; (e) medicines which are available without a prescription; (f) problems related to erectile dysfunction; (g) the purchase of food or nutritional supplements and expenses incurred in the treatment of obesity, whether or not these are prescribed for medical purposes; (h) injectable drugs; and (i) experimental drugs.

EMERGENCY OUT-OF-PROVINCE BENEFIT

The Company will reimburse the reasonable and necessary expenses incurred by an Insured Person for treatment or service as the result of Injury or Sickness while travelling on a trip outside the province or territory of Residence, subject to a maximum trip duration of 30 days. All expenses must be incurred on a non-elective Emergency basis. Insurance takes effect on the date of departure from the province or territory of Residence in Canada and terminates on the earliest of (a) the date of return to the province or territory of Residence in Canada or (b) 30 days following the date of departure. Coverage is not applicable while the Insured Person is in his country of domicile. Travel to the United States or Mexico during the term of insurance is valid except for United States residents returning to the United States and Mexican residents returning to Mexico.

FAMILY TRANSPORTATION BENEFIT

In the event an Insured Person is confined to Hospital as an in-patient due to Injury or Sickness and the attendance of a Member of the Immediate Family is certified as medically necessary by the attending Physician, the Company will reimburse up to a maximum of $1,500.00 for transportation costs by the most direct route incurred by such Member of the Immediate Family.

REPATRIATION BENEFIT

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

RETURN HOME BENEFIT

If Injury or Sickness totally incapacitates an Insured Person, the Company will pay the reasonable and necessary expenses actually incurred for returning the Insured Person by the appropriate means of transportation to his country of domicile. All travel arrangements must be approved by the Company prior to departure and are limited to a maximum of $5,000.00.

PRE-EXISTING CONDITIONS

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

MAXIMUM LIMIT OF INDEMNITY

With the exception of the parts titled Return Home Benefit and Repatriation Benefit, the total amount payable under the policy for reimbursement of all expenses, will not exceed the Maximum Limit of Indemnity of $1,000,000.00 per policy year.

EXCLUSIONS AND LIMITATIONS

A. The policy does not cover loss, fatal or non-fatal, caused by or resulting from:

(a) declared or undeclared war or any act thereof;

(b) terrorist activity of any kind;

(c) any loss as the sole result of the utilization of Nuclear, Chemical or Biological weapons of mass destruction howsoever these may be distributed or combined;

(d) active full-time service in the armed forces of any country;

(e) suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;

(f) the commission or the attempt to commit a criminal act by the Insured Person;

(g) alcohol related illness or disease, or the abuse of medication, drugs, alcohol or other toxic substances, non-compliance with prescribed medical therapy or treatment. Alcohol abuse is defined as having a blood alcohol level in excess of 80 mg of alcohol per 100 ml of blood;

(h) participation in professional sports, bodily contact sports, acrobatic or stunt

flying, hang gliding, parachuting, skydiving, parasailing, rock climbing, mountain climbing, bungee jumping, scuba diving, or motorized speed contests;

B. The policy does not cover any of the following supplies or services or costs thereof:

(a) expenses paid under any government/group hospital, medical, dental or health care plan, or expenses for which insurance is prohibited by law;
(b) Hospital visits solely for the administration of drugs;
(c) medical examinations for the use of a third party, including immigration medical check-ups, experimental drugs, preventative medicines or vaccines;
(d) medical examinations specifically for: (i) an application for insurance (or continuance thereof); (ii)an application for a school, camp, association, club, group or program (admission to or continuance at); (iii) an application for employment (or continuance thereof); and (iv) legal requirements or proceedings;
(e) group examinations, immunizations or inoculations and examinations for screening, survey or research purposes;
(f) cosmetic surgery, unless medically necessary as a result of an accident;
(g) charges for any experimental medical treatments;
(h) services for which no charge would ordinarily be made if there was no insurance coverage;
(i) acupuncture procedures;
(j) contraceptive devices of any form;
(k) treatments and consultations related to infertility;
(l) voluntary termination of pregnancy;
(m) pregnancy or childbirth, except complications of pregnancy which will be treated as any other Sickness.
(n) any elective treatments or surgeries;
(o) laboratory or clinical pathology, other than as provided under part titled "Medical Reimbursement Expenses";
(p) expenses incurred outside of the province or territory of Residence, except as provided under the part titled "Emergency Out-of-Province Benefit";
(q) expenses incurred for eyeglasses and contact lenses, or prescriptions therefor;
(r) expenses incurred for dental treatment, nor the cost of replacement or repair of artificial teeth, dentures or dental appliances, other than as provided under part titled "Accidental Dental Reimbursement Benefit" and "Dental Treatment Benefit";
(s) travelling time or mileage;
(t) advice by telephone; and
(u) court testimony, preparation of records, reports, certificates or communications.

C. With respect to the part titled "Emergency Out-of-Province Benefit", the policy does not provide payment or indemnity for expenses incurred directly or indirectly as a result of:

(a) pregnancy or complications thereof within eight weeks of the expected termination date of pregnancy;
(b) any ailment or condition for which an Insured Person undertakes a journey for the purpose of securing or with the intent of receiving medical attention, prescription drugs or medicine, or Hospital services;
(c) hospitalization expenses incurred after the first 48 hours of hospitalization without prior approval from the Company;
(d) any elective (non-Emergency) treatment or surgery: (i) not required for

the immediate relief of acute pain and suffering; (ii) which medically could be delayed until the Insured Person has returned to his province or territory of Residence; and (iii) which the Insured Person elects to have rendered or performed outside his province or territory of Residence following Emergency treatment for or diagnosis of a medical condition which, on medical evidence, would not prevent the Insured Person from returning to his province or territory of Residence prior to such treatment or surgery.

In consultation with the attending Physician, the Company reserves the right to transfer an Insured Person to another Hospital or return an Insured Person to Canada or country of domicile for necessary treatment. In the event the Insured Person refuses to comply, the Company may no longer be liable for further expenses incurred, which are related to the condition causing the treatment, after the proposed transfer date.

EFFECTIVE DATE OF INSURANCE OF AN INSURED ERSON

Each person who is eligible for insurance under the policy shall become an Insured Person on the later of;

(a) the effective date of the policy with respect to an eligible person on or before the effective date of the policy;
(b) the date he becomes eligible for insurance hereunder if eligible after the effective date of the policy;
(c) the date the Policyholder advises in writing that coverage should commence.

TERMINATION OF INSURANCE OF AN INSURED PERSON

Insurance with respect to each Insured Person will immediately terminate on the earliest of the following dates:

(a) the date the policy is terminated;
(b) the premium due date if the Policyholder fails to pay the required premium for an Insured Person, except as the result of an inadvertent error;
(c) the date an Insured Person reaches 70 years of age;
(d) the date an Insured Person ceases to be associated with the Policyholder in a capacity making such person eligible for insurance hereunder;
(e) the date an Insured Person becomes eligible under either a Canadian federal and/or provincial health and hospitalization insurance plan.
(f) the date an Insured Person returns to his country of domicile;
(g) the date an Insured Person withdraws from classes with the Policyholder.

Termination of the insurance of any Insured Person will not prejudice consideration of any claim submitted within 90 days of such termination as a result of Injury or Sickness which occurred prior to such termination. In the event the Insured Person is hospitalized as a result of Injury or Sickness, prior to the termination of insurance, benefits will be paid provided treatment is continuous for such Injury or Sickness, subject to the terms and provisions of the policy in effect as of the date of the termination of insurance. However, benefits will not be payable for any expenses incurred after the Insured Person is no longer confined as an inpatient in a Hospital or 12 months from the first day of hospitalization, whichever occurs first.

RECURRENT INJURY OR SICKNESS

If an Injury or Sickness causes the Insured Person to incur eligible expenses following which a continuous period of six or more months elapses, during which the same Injury or Sickness does not cause the Insured Person to incur any eligible expenses and does not require any treatment of the Insured Person by a Physician, the Insured Person will be deemed to have recovered from the Injury or Sickness at the end of the period of six or more months.

Thereafter, a subsequent recurrence of the Injury or Sickness which causes the Insured Person to incur eligible expenses will be deemed to be a different Injury or Sickness to which the full maximum reimbursement limit will be applicable without any reduction or variation by reason of eligible expenses incurred as a result of the Injury or Sickness from which the Insured Person was deemed to have recovered.

NON-DUPLICATION

Any benefits normally payable under any other insurance policy or plan that duplicate benefits payable under the policy will be co-ordinated with the policy to the extent that the aggregate reimbursement does not exceed the total expenses incurred. The Company may, at its discretion, require from the Insured Person an assignment of all right of recovery against any other party for loss to the extent that payment is made hereunder.

HOW TO SUBMIT A CLAIM

Industrial-Alliance *Pacific* Life Insurance Company (IAP)
Claims Department
2165 West Broadway, P.O. Box 5900
Vancouver, BC V6B 5H6
1 (800) 549 7227 or
outside North America, collect 1 (604) 737 9377

MEDICAL CLAIMS

When an Insured Person encounters a medical situation that requires treatment or hospitalization, a claim form should be obtained from the Administrator and presented to your Physician and/or Hospital for completion.

Some Physicians and/or Hospitals MAY accept an assignment of the claim, in which case the claim/bill will be forwarded directly to IAP for adjudication.

IAP MUST be notified of pre-scheduled surgery three days prior to admission and within 48 hours of admission for unscheduled Hospital stays.

Completed claim forms should be forwarded to IAP at the above-noted address with all ORIGINAL RECEIPTS for any eligible expenses incurred.

EMERGENCY OUT-OF-PROVINCE CLAIMS

IAP Emergency Assistance
24 hours a day - 7 days a week.
Call 1 (800) 255 2008 or
outside North America, collect 0 (305) 865 8895

If possible, before obtaining any medical services, please call IAP Emergency Assistance to be directed to a facility in your area of travel and to ensure that the medical attention you receive is covered. If you do not contact IAP Emergency Assistance, you may receive inappropriate or unnecessary medical treatment which may not be included in this coverage. Please ensure you tell the operator that you are covered by Industrial-Alliance *Pacific* Life Insurance Company in order that your eligibility may be established.

When you return to your province of residence you will be required to submit a claim directly to IAP. Claim forms may be obtained by contacting IAP Claims Department.

HOW TO FILE A CLAIM

Please make sure that, if you pay any expenses yourself, you obtain ORIGINAL RECEIPTS and forward to IAP along with the completed claim form.

In the event of a claim, documentary evidence of the duration of your scheduled trip, such as a transportation ticket or an official stamp at a customs office will be required.

Industrial-Alliance *Pacific* Life Insurance Company, IAP Emergency Assistance or their agents shall not be responsible for the availability, quality or results of any medical treatment or the failure of the Insured Person to obtain medical treatment.

Underwritten by **Industrial-Alliance *Pacific* Life Insurance Company.**

INDUSTRIAL ALLIANCE *PACIFIC*™
INSURANCE AND FINANCIAL SERVICES™

This summary is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Master Policy issued by Industrial-Alliance Pacific Life Insurance Company.