GMS

Personal Health Coverage

Effective June 1, 2017

Choice. Value. Service.

Unexpected health care needs can place additional financial burdens on an individual or family. Our Personal Health Coverage supplements your provincial health plan to ensure you're covered for everyday health needs, medical emergencies and rising drug and dental costs. We'll help you feel protected between the lines.

Choice. With a selection of plan types and options, you design the plan that best meets your family's unique needs.

Value. GMS offers you true value with health plans and options at affordable, competitive rates.

Service. Your claims are processed quickly, and when you use our pay-direct card at a participating pharmacist or dentist, your claims are processed automatically—no need to submit receipts.

If you have any questions about your health plan you can always contact GMS Customer Care toll-free at **1.800.667.3699** or email **info@gms.ca**.

Personal Health Plan Types

BasicPlan

Ideal coverage for unexpected emergencies including those essential health benefits not covered under your provincial health plan—like ambulance services, preferred hospital rooms and in-hospital drugs.

ExtendaPlan®

Comprehensive insurance with a wide range of benefits, including coverage for medical emergencies, medical supplies and equipment, and a variety of health specialists.

OmniPlan®

Your premier health insurance choice. You receive extensive health benefit coverage including: health practitioner services like physiotherapy and massage therapy; vision care; glasses; and much more.

Additional Coverage Options

Basic Prescription Drug

Coverage for prescription drugs listed under your provincial drug plan (formulary). Use our convenient pay-direct card and reduce out-of-pocket expenses.

Enhanced Prescription Drug

Coverage for prescription drugs listed under your provincial drug plan (formulary), including oral contraceptives. Up to $800 of coverage can be used for prescription drugs for pre-existing medical conditions and legal prescriptions for drugs not listed under your provincial drug plan (including special status drugs). This additional coverage option also includes our convenient pay-direct card.

Dental Care

Coverage for basic procedures (oral exams, polishing, fillings) and major services including crowns, bridges, dentures, inlays and onlays.

Hospital Cash

Daily cash allowance of $100 per day to enhance your personal comfort while in hospital.

Annual Travel

Emergency medical travel insurance that covers you for multiple trips during the year. Your choice of 15, 30, or 48 days per trip.

Personal Health Plan Types
Summary of Benefits

Benefits	BasicPlan	ExtendaPlan®	OmniPlan®
Eye Exams	n/a	$90 / 2 years	$90 / 2 years
Eyeglasses & Contact Lenses	n/a	Included in Eye Exams limit	$200 / 2 years
Health Practitioners	n/a	$35/visit, $250 combined maximum	$35/visit, maximum $300 per specialty
Hearing Aids*	n/a	$500 / 5 years	$800 / 5 years
Health Supplies & Equipment	n/a	$500	$500
Diabetic Supplies & Equipment	n/a	$300	$300
Oxygen Equipment	n/a	$500/year; $1,500 lifetime maximum	$500/year; $2,500 lifetime maximum
Blood Pressure Monitors	n/a	1 / policy / 5 years	1 / policy / 5 years
Custom Made Foot Orthotics	n/a	80% / 5 years	80% / 3 years
Orthopedic Shoes	n/a	$225	$225
Mobility Aids	n/a	$300	$300
Ostomy Supplies	n/a	$300	$300
Funeral Expenses	n/a	n/a	$4,000
Out-of-Province Referral	n/a	$50,000 lifetime maximum / person	$50,000 lifetime maximum / person
Ambulance	$2,000	Unlimited	Unlimited
Air Ambulance	Unlimited	Unlimited	Unlimited
Casts & Crutches	Unlimited	Unlimited	Unlimited
Preferred Hospital Rooms	$500	$1,000	45 days to $3,500
Private Duty Nursing	80% to $1,500 (in-*hospital* only)	80% to $3,000	80% to $5,000
In-Hospital Drugs	$1,000	$1,000	$2,000
Accidental Dental	$500 / injury	$2,000 / injury	$5,000 / injury
Wheelchairs, Motorized Scooters & Adjustable Beds*	$500 / person / 5 years	$750 / person / 5 years	$1,000 / person / 5 years
Artificial Limbs, Eyes & Larynx	$5,000	$5,000	$5,000
Patient Walkers	80% to $300 / person / 5 years	80% to $300 / person / 5 years	80% to $300 / person / 5 years
Breast Prosthesis	$175 single; $350 bi-lateral / 2 years	$325 single; $650 bi-lateral / 2 years	$325 single; $650 bi-lateral / 2 years

Additional Coverage	
Basic Prescription Drug†	Payment up to $3,500 for prescription drugs.
Enhanced Prescription Drug†	Payment to an overall maximum of $5,000 for prescription drugs and oral contraceptives. Includes $800 for pre-existing medications.
Dental Care*	Preventative Care, Basic and Major Services. Year 1 $500, Year 2 $750, Year 3+ $1,000.
Hospital Cash*	$100 per day up to a maximum of $3,000 per policy year.
Annual Travel (emergency medical coverage while travelling)	Out-of-country and out-of-province coverage $2,000,000; 15, 30 or 48 days

This is a summary of benefits only. Please refer to the policy wording for complete details.
†*Newly prescribed drugs are limited to those covered under your provincial drug plan (formulary).*
**Subject to a waiting period.*

IMPORTANT NOTICE

PLEASE READ YOUR POLICY WORDING CAREFULLY

What am I covered for?

Your health insurance policy provides coverage under one of three health plan types, either BasicPlan, ExtendaPlan® or OmniPlan®. Prescription drugs, Annual Travel, Dental Care, and Hospital Cash are additional coverage options that must be purchased along with, and in addition to, your health plan. Please refer to your receipt, renewal invoice or the letter accompanying your GMS ID card to see which options you have purchased.

How do I make a health benefit claim?

Online - register for a My GMS account at www.gms.ca. Your account gives you access to an easy-to-use online claim form that allows you to attach copies of your receipts and submit a claim in minutes. You can also sign up to have your claim payments directly deposited into a bank account.

Mail - claim forms are available for download at www.gms.ca. Complete the form, attach your receipts and mail to GMS.

How do I make a prescription drug claim?

If you have purchased prescription drug coverage, you will receive a GMS pay-direct card by mail shortly after your purchase. You can present this card to participating pharmacists for automated claims payments. In this case, you do not need to submit an additional claim form.

Does my plan include coverage for medical emergencies while travelling?

If you have included the the Annual Travel additional coverage option with your health plan, you have coverage for medical emergencies while travelling outside your province of residence. Refer to your receipt, renewal invoice or the letter accompanying your GMS ID card to see which additional coverage options you have purchased.

Please read your policy carefully before travelling as your insurance has exclusions, conditions and limitations.

What should I do if I have a travel emergency or claim?

For medical emergencies and assistance, the GMS Travel Assistance Centre is available 24-hours a day, 7 days a week, by telephone. In the event of a medical emergency, immediately call toll-free 1.800.459.6604 (within Canada & USA) or collect to 905.762.5196 (from all other locations).

Is my personal information private and protected?

We are committed to protecting the privacy of our clients. To review the GMS privacy policy visit our website at www.gms.ca

Note: This policy contains words printed in *italics* which indicates they are defined terms as detailed in the definitions section.

Policy Wording Contents

Policy Wording

This policy contains a provision removing or restricting the right of the insured to designate a person to whom or for whose benefit insurance money is to be payable.

HEALTH

Benefits provided by this policy are available when deemed medically necessary and provided by a *physician* or licensed health care professional.

GMS will pay *reasonable and customary* charges up to the maximum amounts set out in each benefit subject to exclusions and limitations.

Claims must be submitted within twelve (12) months from the date of service and no later than thirty (30) days following the expiry date of the policy.

A. Health Benefits

1. **Eye Exams** – provides payment for eye exams, including refractions.

   The benefit does not cover eye exams related to surgical procedures or any form of optical surgery.

OmniPlan®	**ExtendaPlan®**
$90 maximum per person in the two (2) most recent *policy years*	$90 maximum per person in the two (2) most recent *policy years*

2. **Eyeglasses and Contact Lenses** – provides payment for prescription eyeglasses, prescription sunglasses and prescription contact lenses (including toric lenses used for the purpose of remedying astigmatism) and/or corrective laser eye surgery. Eyeglasses and contact lenses must be prescribed by an optometrist or *physician*.

   The benefit does not cover non-prescription eyeglasses, non-prescription sunglasses or non-prescription contact lenses used for cosmetic purposes.

OmniPlan	**ExtendaPlan**
$200 maximum per person in the two (2) most recent *policy years*	Included in Eye Exams limit

3. **Health Practitioners** – provides payment for the *services* of an acupuncturist, chiropractor, chiropodist/podiatrist, clinical psychologist, massage therapist, naturopath, speech therapist and physiotherapist. All *services* must be provided by health practitioners who are legally authorized by an appropriate governing association to practice their profession and must be a non-*family member*.

   GMS reserves the right to verify the medical necessity of *services* rendered and to determine which health practitioner(s) will be eligible for reimbursement.

   GMS reserves the right to request a referral from *your physician* if a *service* for the same *medical condition* continues beyond twelve (12) months.

   The benefit does not cover diagnostic and investigative testing.

OmniPlan	**ExtendaPlan**
$35 maximum per visit to a maximum of $300 per specialty, per person, per *policy year*	$35 maximum per visit to a maximum of $250 (for all health practitioners combined), per person, per *policy year*

4. **Hearing Aids** – provides payment for hearing aids fitted by an audiologist or hearing aids deemed necessary by an audiogram conducted by an audiologist.

   This benefit is subject to a one (1) year waiting period from the date of enrolment.

   This benefit does not cover the cost of audiograms, hearing tests, hearing aid fitting services, batteries and/or additional or replacement ear moulds.

OmniPlan	**ExtendaPlan**
$800 maximum per person in the five (5) most recent *policy years*; applies to purchase or repair	$500 maximum per person in the five (5) most recent *policy years*; applies to purchase or repair

5. **Health Supplies and Equipment** – provides payment for the following supplies and equipment prescribed by a *physician*.

   Purchase and/or rental of:

   a. splints;
   b. braces containing metal or hard plastic components.

   Purchase of:

   a. aero chambers;
   b. air casts;
   c. cervical collars;
   d. clavicle straps;
   e. cryo cuffs
   f. embolic stockings (4 pairs/per person/per *policy year*);
   g. lymphedema sleeves;
   h. rib belts;
   i. sacroiliac corsets;
   j. shoulder immobilizers;
   k. trusses; and/or
   l. wigs.

   When medically necessary, approval for medical supplies and equipment not listed above and prescribed by a *physician* can be submitted for consideration. Approval is at *GMS'* discretion.

OmniPlan	**ExtendaPlan**
$500 overall maximum per person, per *policy year*	$500 overall maximum per person, per *policy year*

6. **Diabetic Supplies and Equipment** – provides payment for the purchase of diabetic supplies and equipment, including insulin pumps and testing devices, when prescribed by a *physician* for personal use in the *home*.

   This benefit does not cover insulin and other *prescription drugs*.

OmniPlan	**ExtendaPlan**
$300 maximum per person, per *policy year*	$300 maximum per person, per *policy year*

7. **Oxygen Equipment** – provides payment for the purchase or rental of oxygen equipment and/or CPAP supplies when prescribed by a *physician* for personal use in the *home*.

   This benefit does not cover CPAP machines or the cost of oxygen.

OmniPlan	**ExtendaPlan**
$500 maximum per person, per *policy year*, to a lifetime maximum of $2,500 per person	$500 maximum per person, per *policy year*, to a lifetime maximum of $1,500 per person

8. **Blood Pressure Monitors** – provides payment for the purchase of a blood pressure monitor when prescribed by a *physician* for personal use in the *home*.

OmniPlan	**ExtendaPlan**
Maximum one (1) per policy in the five (5) most recent *policy years*	Maximum one (1) per policy in the five (5) most recent *policy years*

Health Plan Benefits

9. **Custom Made Foot Orthotics** – provides payment for custom made foot orthotics.

   An accredited podiatric biomechanics laboratory must create the orthotic using a 'cast or scan' and raw materials.

   An approved practitioner such as a pedorthist, chiropodist/podiatrist or certified orthotist must provide a professionally developed 'cast or scan' using a:

   a. three-dimensional model of the foot, which includes foam box impression, plaster casting or direct mould; or
   b. digital impression of the foot.

   This benefit does not cover the cost of assessment, 'cast or scan' or off-the-shelf orthotics.

OmniPlan®	**ExtendaPlan®**
80% to a maximum of one pair per person, in the three (3) most recent *policy years* for adults and one pair per person per *policy year* for children under sixteen (16) years of age	80% to a maximum of one pair per person, in the five (5) most recent *policy years* for adults and one pair per person per *policy year* for children under sixteen (16) years of age

10. **Orthopedic Shoes** – provides payment for the cost of one (1) pair of custom-made shoes or the cost to modify one (1) pair of off-the-shelf orthopedic shoes, medically necessary to accommodate severe foot abnormalities such as a:

    a. congenital deformity;
    b. traumatic injury; or
    c. disease that affects one or both feet (i.e. diabetes, arthritis or osteomyelitis).

    To be eligible for coverage a written prescription, including a medical *diagnosis*, is required from an orthopedic surgeon, an attending *physician*, pedorthist, chiropodist/podiatrist or certified orthotist.

    For the shoe to be covered it must be custom-made using raw materials and created from a custom-made 'last' of *your* foot. A 'last' is an accurate three-dimensional model of an individual's foot and ankle designed from a 3-D cast of the person's foot. The shoe is built around this 'last' from patterns reflecting its true individual design. The shoe must also be dispensed by a pedorthist, chiropodist/podiatrist or certified orthotist.

    For modification of off-the-shelf orthopedic footwear to be covered it must be medically necessary, prescribed and modified by a pedorthist, chiropodist/podiatrist or certified orthotist. The cost of the off-the-shelf orthopedic shoe is not covered unless supplied by the certified professional modifying the shoe.

OmniPlan	**ExtendaPlan**
$225 maximum per person, per *policy year*	$225 maximum per person, per *policy year*

11. **Mobility Aids** – provides payment for the purchase of the following mobility aids such as: canes, reaching aids, raised toilet seats, grab bars, bathtub/toilet safety rails, and bathtub/transfer benches.

    Receipts must be accompanied with a prescription from a *physician* confirming medical necessity and the aids are intended for personal use in the *home*. Canes and reaching aids will also be reimbursed if used in personal care homes and nursing homes.

OmniPlan	**ExtendaPlan**
$300 maximum per person, per *policy year*	$300 maximum per person, per *policy year*

12. **Ostomy Supplies** – provides payment for ostomy supplies when required for personal use in the *home*.

OmniPlan	**ExtendaPlan**
$300 maximum per person, per *policy year*	$300 maximum per person, per *policy year*

13. **Funeral Expenses** – provides payment for funeral expenses provided the death is *accidental* and not the direct or indirect result of sickness or disease.

    GMS requires a death certificate or a satisfactory statement of death such as a *physician*'s letter and receipts for the funeral expenses.

    OmniPlan

    $4,000 maximum per person

14. **Out-of-Province Referral** – provides payment for *physician*, anaesthetic, radiology, laboratory, *hospital* and ambulance services outside *your province of residence* for *treatment* which is not available in *your province of residence*, when recommended in writing by a specialist *physician*.
    Pre-approval by *GMS* is required.

    The benefit does not cover *treatment*:

    a. where there are provincially funded *treatment* options in *your province of residence*;
    b. related to any condition, disease or illness that existed within the twelve (12) months prior to the application date; or
    c. *treatment* administered outside of Canada.

OmniPlan	**ExtendaPlan**
$50,000 lifetime maximum per person	$50,000 lifetime maximum per person

15. **Ambulance** – provides payment for emergency transport by licensed professional road ambulance to the nearest *hospital* or health centre equipped to provide the necessary emergency in-patient and out-patient *treatment*.

    50% of the cost of road ambulance transport returning *you* to *your* place of permanent residence will be paid if *you* are bedridden upon discharge from *hospital*.

    This benefit does not cover payment when no transport occurs or for *transportation* to or from *physicians*' offices, laboratories and medical clinics.

OmniPlan	**ExtendaPlan**	**BasicPlan**
Unlimited	Unlimited	$2,000 maximum per person, per *policy year*

16. **Air Ambulance** – provides payment for emergency transport by a licensed professional air ambulance to the nearest *hospital* or health centre equipped to provide the necessary emergency in-patient and/or out-patient *treatment*, when authorized by a *physician*.

    The service must occur within *your province of residence*.

OmniPlan	**ExtendaPlan**	**BasicPlan**
Unlimited	Unlimited	Unlimited

17. **Casts and Crutches** – provides payment of the cost for fibreglass casts and for the purchase or rental of crutches.

OmniPlan	**ExtendaPlan**	**BasicPlan**
Unlimited	Unlimited	Unlimited

Health Plan Benefits

18. **Preferred *Hospital* Room** – provides reimbursement of private or semi-private *hospital* room costs. *Your* policy must have been purchased and be in effect prior to the *hospital* admittance date.

    The benefit does not cover stays for convalescent and respite care.

OmniPlan®	**ExtendaPlan®**	**BasicPlan**
Maximum 45 days per person, per *policy year*, to an overall maximum of $3,500 per person per *policy year*	$1,000 maximum per person, per *policy year*	$500 maximum per person, per *policy year*

19. **Private Duty Nursing** – provides payment for private duty nursing services. Services must be prescribed by a *physician*. Services must be rendered by a registered nurse or licensed practical nurse, who is not immediately related to *you* or who does not ordinarily reside in *your home*.

    For plans where in-*home* care is included, the nursing services must commence immediately following *your* release from the *hospital* and be consistent with the *treatment* of the condition for which *you* were hospitalized.

    The benefit does not provide coverage if *you* were in *hospital* prior to the *effective date* of the policy.

OmniPlan	**ExtendaPlan**	**BasicPlan**
80% to $5,000 maximum per person, per *policy year*; includes in-*hospital* and in-*home* care	80% to $3,000 maximum per person, per *policy year*; includes in-*hospital* and in-*home* care	80% to $1,500 maximum per person, per *policy year*; includes in-*hospital* care only

20. **In-*Hospital* Drugs** – provides payment for the cost of drugs supplied and administered as *treatment* for in-patient care while hospitalized and when not covered by *your* provincial *prescription drug* service plan.

    The benefit does not cover pre-existing drugs, fertility drugs, drugs for *treatment* of sexual dysfunction, lifestyle drugs, experimental drugs, diet drugs, drugs used for cosmetic purposes, drugs normally available over the counter and/or drugs used for the cessation of smoking.

OmniPlan	**ExtendaPlan**	**BasicPlan**
$2,000 maximum per person, per *policy year*	$1,000 maximum per person, per *policy year*	$1,000 maximum per person, per *policy year*

21. ***Accidental* Dental** – provides payment for the services of a *dentist* necessitated by *accidental* injury to natural or permanently attached artificial teeth, such as a direct blow to the mouth, but not by an object placed in the mouth.

    You must notify *GMS* and receive approval for *treatment* no later than six (6) months from the date of injury. All *treatment* must be completed within twelve (12) months of the date of injury. Payment will not be made for any injury which occurred prior to *you* being covered under this policy or for any *treatment* incurred after the termination date of this policy.

    The cost to replace or repair dental implants will be limited to the cost of a crown only.

    Payment by *GMS* will be limited to the most cost effective *treatment* within acceptable dental standards. Should *you* and *your dentist* choose a more expensive *treatment*, *you* are responsible for any additional charges beyond the allowance for the alternative service. Where there is a dispute as to the most cost effective *treatment* within dental standards, the determination of *GMS* shall be final.

OmniPlan	**ExtendaPlan**	**BasicPlan**
$5,000 maximum per injury	$2,000 maximum per injury	$500 maximum per injury

22. **Wheelchairs, Motorized Scooters and Adjustable Beds** – provides payment for the purchase or rental of wheelchairs, geriatric chairs, motorized scooters, and/or adjustable beds when prescribed by a *physician*.

    The benefit is subject to a one (1) year waiting period from enrolment in the plan.

    The benefit does not cover adjustable beds for individuals confined to, or resident in an active *treatment hospital*, convalescent facility, nursing home, extended care facility, rehabilitation centre, rest home or personal care home.

OmniPlan	**ExtendaPlan**	**BasicPlan**
$1,000 maximum per person, per policy in the five (5) most recent *policy years*	$750 maximum per person, per policy in the five (5) most recent *policy years*	$500 maximum per person, per policy in the five (5) most recent *policy years*

23. **Artificial Limbs, Eyes and Larynx** – provides payment for the purchase of artificial limbs, eyes and/or larynx.

    The benefit does not cover myoelectric limbs.

OmniPlan	**ExtendaPlan**	**BasicPlan**
$5,000 maximum per person, per *policy year*	$5,000 maximum per person, per *policy year*	$5,000 maximum per person, per *policy year*

24. **Patient Walkers** – provides payment of the cost to purchase or rent patient walkers.

    The walker must be prescribed by a *physician*.

OmniPlan	**ExtendaPlan**	**BasicPlan**
80% to $300 maximum per person, per policy in the five (5) most recent *policy years*	80% to $300 maximum per person, per policy in the five (5) most recent *policy years*	80% to $300 maximum per person, per policy in the five (5) most recent *policy years*

25. **Breast Prosthesis** – provides payment for the purchase of an artificial breast prosthesis.

    The benefit does not cover surgical bras.

OmniPlan	**ExtendaPlan**	**BasicPlan**
$325 maximum for *single* mastectomy patients or $650 maximum for bilateral mastectomy patients; in the two (2) most recent *policy years*	$325 maximum for *single* mastectomy patients or $650 maximum for bilateral mastectomy patients; in the two (2) most recent *policy years*	$175 maximum for *single* mastectomy patients or $350 maximum for bilateral mastectomy patients; in the two (2) most recent *policy years*

Health Plan Benefits

B. Health Benefit Conditions

In addition to the General Conditions listed on page 27, the following conditions apply to health benefits under this policy.

1. ***Reasonable and Customary*** – reimbursement for goods and services purchased will be based on *reasonable and customary* charges.
2. **Where Supplies can be Purchased** – goods may be purchased anywhere within Canada. Vision goods may be purchased worldwide. Reimbursement will be based on the lowest of either the purchase price or the available price within *your province of residence*.
3. **Where Services are Provided** – for BasicPlan and ExtendaPlan®, services must be provided within *your province of residence*. For OmniPlan®, services may be provided anywhere within Canada, unless otherwise stated.

ADDITIONAL COVERAGE OPTIONS

You may add to *your* OmniPlan®, ExtendaPlan® or BasicPlan, for an additional premium:

- Annual Travel;
- Dental Care;
- Basic *Prescription Drug*;
- Enhanced *Prescription Drug*; and/or
- *Hospital* Cash.

Annual Travel

You may add to *your* OmniPlan, ExtendaPlan, or BasicPlan, for an additional premium.

IMPORTANT TRAVEL NOTICE

What is Travel Insurance?

- Travel insurance is designed to cover losses resulting from sudden, unexpected and unforeseeable circumstances. It is important that *you* read and understand *your* policy before *you* travel as *your* coverage may be subject to certain exclusions or limitations.

What is not covered?

- *Your* policy may not provide coverage for *medical conditions* and/or symptoms that existed before *your trip*. Check to see how this applies in *your* policy and how it relates to *your departure date*, date of purchase or *effective date*.

What should I expect if I have to make a claim?

- *Your* policy provides travel assistance for medical emergencies. If *you* experience a *medical emergency*, *you* must notify our assistance centre prior to *treatment*, where possible, and no later than twenty-four (24) hours after receiving medical *treatment* or being admitted to *hospital*. *Your* policy may limit benefits should *you* not contact the assistance centre.
- In the event of an *accident*, injury or sickness, *your* prior medical history shall be reviewed when a claim is made.
- In the event of a claim, *you* must provide proof of *departure date* and *return date* and will be asked to provide original expense invoices.
- Refer to the Making a Claim section to understand *your* obligations when making a claim.

What happens if there is a change(s) in my health after I apply for coverage?

- Should any changes in *your* health occur after the application date *GMS* must be contacted and *your* application updated. Changes in *your* health constitute a change in stability and may limit *your* available coverage.

PLEASE READ *YOUR* POLICY CAREFULLY AT THE TIME OF PURCHASE

GMS will pay the *reasonable and customary* charges up to the maximum provided by the plan option *you* have chosen, as shown in the chart below, and subject to individual benefit limits. The number of days per *trip* and the maximum amount of coverage depends on the plan option *you* have chosen. The travel benefit is not subject to a waiting period.

	15 Day Option	30 Day Option	48 Day Option
Number of days per *trip* outside of Canada†	15 days	30 days	48 days
Number of days per *trip* inside of Canada	183 days	183 days	183 days
Maximum aggregate limit per person, per year	$2,000,000	$2,000,000	$2,000,000

† *Must be under 80 years of age on the effective date or renewal of the plan for coverage outside of Canada. See 1. under section C. Travel Conditions for more details.*

A. Travel Benefits

In the event of a *medical emergency* that occurs outside of *your province of residence*, unless otherwise stated, *GMS* will pay *reasonable and customary* expenses on *your* behalf, as described in the option chosen. Where a listed benefit indicates a maximum limit, the limit is applied per person, per *policy year*. These benefits are only available if *you* have purchased the Annual Travel option.

1. **In-*Hospital* Care** – expenses for:
   a. ward or semi-private *hospital* accommodations;
   b. *hospital* services and supplies; and
   c. medical *treatment* while in-*hospital*.

   One follow-up visit is covered if it is deemed medically necessary and directly related to the covered *medical emergency*. The follow-up visit must occur within fourteen (14) days of discharge. This benefit does not provide coverage for ongoing *treatment* necessary to treat any *medical condition* once the *medical emergency* has ended.
2. ***Physician* Services** – expenses for medical *treatment* from a *physician*.
3. **Diagnostic Services** – expenses for basic diagnostic tests. Pre-approval by *GMS* is required for advanced diagnostic testing, including but not limited to, magnetic resonance imaging, computerized axial tomography (CAT) scans, sonograms, ultrasounds, and biopsies.
4. **Out-Patient Medical *Treatment*** – expenses for out-patient medical *treatment*.
5. ***Prescription Drugs*** – expenses for *prescription drugs* prescribed by an attending *physician* and supplied by a licensed pharmacist. *GMS* covers a maximum supply of thirty (30) days per prescription. Over-the-counter drugs are not covered whether they have been prescribed or not.

   Prescription drugs that are lost, stolen or damaged during *your trip* are covered up to a maximum of $50 per prescription. *Physician*'s expenses related to replacement are not covered.

6. **Rental of Essential Medical Appliances** – expenses for the rental of essential medical appliances such as a wheelchair, crutches, canes etc., when needed due to a *medical emergency* that occurred on *your trip*. The rental expense must not exceed the cost to purchase the appliances. Pre-approval by *GMS* is required.
7. **Emergency Dental Services** – expenses, to a maximum of $2,000, due to an *accidental* blow to the mouth that requires the repair or replacement of natural teeth or permanently attached artificial teeth. Expenses to a maximum of $250 are also covered for the *treatment* or relief of dental pain for any dental emergency other than that caused by an *accidental* blow to the mouth.
8. **Private Duty Nursing** – expenses to a maximum of $5,000 for private duty nursing services performed by a non-*family member* Registered Nurse when ordered by the attending *physician* during in-*hospital* care or in lieu of in-*hospital* care. Pre-approval by *GMS* is required.
9. **Health Practitioners** – expenses to a maximum of $300, per specialty, for the *services* of an osteopath, physiotherapist, chiropractor, chiropodist, or podiatrist.
10. **Road Ambulance** – expenses for the use of a licensed road ambulance in a *medical emergency* where *you* require immediate transport to the nearest *hospital* with adequate facilities.
11. **Air Ambulance** – expenses to a maximum of $20,000 for the use of a helicopter air ambulance in a *medical emergency* involving life threatening circumstances where *you* require immediate transport to the nearest *hospital* with adequate facilities to treat *your medical emergency*. Pre-approval by *GMS* is required for transport between hospitals.
12. **Remote Evacuation** – expenses to a maximum of $20,000 for *your* evacuation to the nearest, most accessible *hospital* from a location inaccessible by road in a *medical emergency* involving life threatening circumstances.
13. **Repatriation** – expenses to transport *you* by air ambulance (excluding helicopters) or regularly scheduled common carrier back to *your province of residence* for further in-*hospital* medical *treatment*, with written recommendation from the attending *physician* confirming that *you* are fit to travel. Pre-approval by *GMS* is required.
14. **Special Attendant** – expense of round-*trip transportation* for the transport of a medical attendant to accompany *you* back to *your province of residence* when ordered by the attending *physician*. The attendant must not be a friend, *family member*, associate or travelling companion. Pre-approval by *GMS* is required.
15. **Return of *Family Member*** – expenses up to $1,000 for one-way air *transportation* to return one (1) accompanying *family member* insured under *your* policy to *your province of residence* when:
    a. *GMS* requires that *you* return to *your province of residence* for further in-*hospital* medical *treatment*; or
    b. in the event of *your* death.

    Pre-approval by *GMS* is required.
16. **Return & Escort of a Dependent Child/Grandchild** – expense of one-way *transportation* to return *your* dependent children, or grandchildren travelling with *you*, who are under the age of eighteen (18) to *your province of residence* when *you* have been returned to *your province of residence* for further in-*hospital* medical *treatment*. When necessary, round-*trip transportation* for an arranged escort will be provided for under this benefit. Pre-approval by *GMS* is required.
17. ***Family*/Friend to Bedside** – expenses to a maximum of $3,000 for round-*trip* air *transportation* for a *family member* or a close friend to visit *you* if *you* are travelling without a *family member* on night three (3) and subsequent nights of in-*hospital* care as a result of a *medical emergency* when ordered by the attending *physician*. Pre-approval by *GMS* is required.

    GMS will reimburse up to $150 per day to a maximum of $750 for the expenses incurred by the *family member* or close friend while *you* are hospitalized. Original receipts must be submitted to be eligible for reimbursement.
18. **In Event of Death** – expenses up to $2,000 for round-*trip* air *transportation* to provide for the return of a *family member* who is required to attend to identify *your* remains in the case of *your* death due to a *medical emergency*. *GMS* will also reimburse up to $300 combined for meals and accommodations incurred during travel. Pre-approval by *GMS* is required.
19. **Return of Remains** – expenses, up to a maximum of $7,000, for the preparation and transport of *your* remains to *your province of residence*, or expenses up to a maximum of $3,000 for *your* cremation or burial at the place of death, when *your* death was a result of a *medical emergency*. This benefit does not cover the cost of a burial casket or urn.
20. **Return of Vehicle** – expenses, up to a maximum of $2,000, to return *your* vehicle to *your province of residence*, or a vehicle rented by *you* to the nearest rental agency, when *you* or any travelling companions are unable to do so because *you* have been returned to *your province of residence* for further in-*hospital* medical *treatment*.

    Reasonable and customary expenses for this benefit include the vehicle being returned by a professional agency or the following incurred by an individual other than yourself returning the vehicle on *your* behalf: fuel, meals, overnight accommodations and one-way air *transportation*. Pre-approval by *GMS* is required.

    Expenses will only be reimbursed if *your* vehicle arrived at *your* destination during the coverage period of this policy.
21. **Return of Cat or Dog** – expenses to a maximum of $300 to return *your* cat or dog to *your province of residence*, when *you* have been returned to *your province of residence* for further in-*hospital* medical *treatment*.
22. **Child Care** – expenses to a maximum of $500 for licensed care of dependent children/grandchildren or mentally or physically challenged persons who rely on *you* for assistance, if they are travelling with *you*, should *you* require in-*hospital* care. Pre-approval by *GMS* is required.
23. **Out-of-Pocket Expenses** – expenses up to a maximum of $1,000 incurred by a travelling companion insured under *your* policy in the event *you* are in *hospital* receiving care on *your return date*. This benefit includes coverage for up to $150/day for accommodations, which shall form part of the $1,000 limit. Pre-approval by *GMS* is required.

GMS is not responsible for the availability, quality, results or effectiveness of any medical *treatment*, *transportation* or other service or *your* failure to obtain medical *treatment*.

B. Travel Exclusions

In addition to the General Exclusions listed on page 31 the following exclusions apply to Travel Benefits:

1. **Stability** – *GMS* does not cover any expenses resulting from *medical condition*(s) which have not been *stable* immediately prior to *your departure date* for:
    a. ninety (90) days for all individuals who were sixty nine (69) years of age and younger as of the *effective date* of this policy;
    b. one hundred and eighty (180) days for all individuals who were age seventy (70) and older as of the *effective date* of this policy; or
    c. three hundred and sixty-five (365) days, regardless of age, for individuals who:
        i. use *home* oxygen for lung and/or heart disease which includes but is not limited to angina, irregular heartbeat, heart attack, ischemic heart disease, valvular heart disease and cardiomyopathy;

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ii. have undiagnosed episodes of fainting or falling (syncope);
iii. suffer from kidney/liver failure;
iv. require insulin to treat diabetes and also take *prescription drugs* for heart disease (as defined in i. above); and/or
v. have congestive heart failure (CHF).

Medical conditions include:

a. *medical condition*(s) for which *you* received medical *treatment* or *medical consultation*; and/or
b. undiagnosed *medical condition*(s) related to symptoms for which *you* received medical *treatment* or *medical consultation*.

You must be *stable* based on the definition of *stable* in this policy, regardless of the opinion of *your physician* or any other person who may provide an opinion on *your medical condition*(s).

2. **Recurrence of a *Medical Condition*** – *GMS* does not cover any expenses for *medical consultation*, medical *treatment* or in-*hospital* care resulting from the continuation, recurrence or complication of an emergency *medical condition*, after such time that the emergency has been deemed to have ended as advised by *GMS*.
3. **Non-Emergency *Treatment*** – *GMS* does not cover any expenses resulting from medical *treatment* that is not a *medical emergency*, including but not limited to: routine or general physical exams; regular care of chronic conditions; elective surgery; dental or cosmetic surgery, even if recommended by a *physician*; and follow ups or continued services following emergency medical *treatment* when not authorized by *GMS*.
4. **Travel for *Diagnosis* or *Treatment*** – *GMS* does not cover any expenses resulting from and/or incurred during *trips* undertaken for the purpose of receiving a *diagnosis* or medical *treatment*.
5. **Delayable *Treatment*** – *GMS* does not cover any expenses for medical *treatment* that can be reasonably delayed until *you* return to *your province of residence*.
6. **Transplants** – *GMS* does not cover any expenses for transplants, including but not limited to organ transplants, or bone marrow or stem cell transplants.
7. **Refusal of Transfer** – *GMS* does not cover any expenses following *your* refusal to transfer to another *hospital* or medical facility capable of providing necessary medical *treatment*, or *your* refusal to return to *your province of residence* when deemed medically necessary.
   Refusal to comply with a transfer request or a request to return to *your province of residence*, when *you* could have been returned to *your province of residence* without endangering *your* life or health, even if the *treatment* available in *your province of residence* could be of lesser quality than the *treatment* available outside *your province of residence* or *you* must go on a waiting list for that *treatment*, will void coverage under this contract from that time forward and will absolve *GMS* of any further liability, whether that liability is related to the initial incident or not.
8. **Refusal to Follow Medical Advice or Advice of *GMS*** – *GMS* does not cover any expenses incurred as a result of *your* refusal to follow medical advice or the advice of *GMS*.
9. **Non-Adherence** – *GMS* does not cover any expenses that result from *your* failure, prior to departure, to:
   a. adhere to medical *treatment*;
   b. obtain investigative or diagnostic tests recommended by a medical professional; and/or
   c. receive results from investigative or diagnostic tests.
10. **Acting Against *Physician*'s Advice** – *GMS* does not cover any expenses when *you* travel against the advice of a *physician*.
11. **Certain Pregnancy Related Matters** – *GMS* does not cover any expenses related to pregnancy, miscarriage, childbirth or complications of any of these conditions occurring after the first eighteen (18) weeks of pregnancy.
12. **Certain Cardiac Procedures and Devices** – *GMS* does not cover any expenses for cardiac catheterization, angioplasty or cardiovascular surgery or insertion of an implantable cardioverter defibrillator (ICD) or pacemaker including all associated diagnostic expenses, unless necessary in a *medical emergency* and pre-approved by *GMS*.
13. **Non-Common Carrier Air Travel** – *GMS* does not cover any expenses resulting from air travel unless riding as a passenger on a common carrier.
14. **Work** – *GMS* does not cover any expenses for work related accidents.
15. **Risky Work or Volunteer Activities** – *GMS* does not cover any expenses resulting from *your* service in the armed forces, willful exposure to peril, work within a hazardous occupation or mission and/or relief work.
16. **Travel Advisory** – *GMS* does not cover expenses arising from any *medical conditions* occurring while *you* are travelling in a country, region, or city for which Global Affairs Canada has issued a travel warning stating that 'non-essential' or 'all travel' be avoided when such travel advisory is issued prior to *your* departure.
17. **Failure to Obtain *GMS* Pre-Approval** – *GMS* does not cover any expenses where pre-approval by *GMS* is required and not obtained.
18. **Pre-Existing Nuclear Issues** – *GMS* does not cover any expenses resulting from any nuclear reaction, radiation or radioactive contamination or occurrence, where the risk of the exposure was present prior to *your* departure, however caused.
19. **Experimental *Treatment*** – *GMS* does not cover any expenses for any medical *treatment* which is considered by *GMS* to be experimental. *GMS*' opinion is final and binding.

C. Travel Conditions

In addition to the General Conditions listed on page 27, the following conditions apply to travel benefits under this policy.

1. **Restricted Travel** – individuals who are age eighty (80) years and older as of the *effective date* of this policy are only eligible for travel benefits within Canada. There is no coverage for travel outside of Canada for individuals age eighty (80) years or older under this policy.
2. **Currency** – all amounts stated in this policy are in Canadian funds.
3. **Interest Charges** – benefits payable shall not include interest charges.
4. **Medical Services Required During Travel** – medical services required during travel must be provided when *you* are outside of *your province of residence* or outside Canada.
5. **Medical Supplies Required During Travel** – goods purchased under this travel benefit can only be purchased when *you* are outside of *your province of residence* or outside Canada.
6. **Purchase Requirement** – the travel benefit must have been purchased prior to *your* departure from *your province of residence* to provide coverage.
7. **Changes in Health** – should any changes to *your* health occur after the application date, *GMS* must be notified and *your* application updated. Changes to health constitute a change in stability and may limit *your* available coverage.
8. **Coordination of Benefits** – if a covered person is entitled to similar benefits under any other individual or group coverage, the benefits payable under this coverage shall be coordinated so that the total payment from all coverage shall not exceed the amount for which the claim is made.

9. **Right to Designate a Person** – *GMS* reserves the right to restrict or deny *your* right to designate persons to whom insurance money is payable.
10. **Medical Transfer** – *GMS*, in consultation with the attending *physician*, reserves the right to transfer *you* to another *hospital* or medical facility or to return *you* to *your province of residence* if deemed medically necessary.
11. **Coverage Limits** – insurance is in effect only for coverage indicated on *your* application for which the premium has been paid. Benefits are payable in accordance with the benefits listed in this policy and where applicable limited to the *sum insured* as indicated.
12. **Service Providers** – *GMS* reserves the right to negotiate amounts payable on *your* behalf with any service provider who provides services covered by this insurance. Payments will be provided directly to the service provider. *You* may not claim or receive more than 100% of covered incurred expenses.

    Payment under this condition is subject to all other policy conditions and limitations.
13. **Payment without Coverage** – payment of any amount by *GMS* on *your* behalf does not constitute a guarantee that *GMS* will cover *your* expenses if *GMS* determines *you* have no coverage under this policy. *You* must repay, on demand, any amount paid or authorized by *GMS* on *your* behalf if and when *GMS* determines that the amount was not payable under the terms and conditions of *your* policy.
14. **Right to Investigate** – *GMS* reserves the right to investigate or obtain a private opinion on any claim and to obtain any and all information relating to a claim.

D. Coverage Begins and Ends

Out-of-province travel coverage begins when *you* depart from *your province of residence*.

Out-of-Canada travel coverage begins when *you* depart from Canada.

Travel coverage ends on the earliest of the day:

1. *you* return to *your province of residence*;
2. *GMS* returns *you* to *your province of residence*;
3. *GMS* ends coverage for a *medical emergency* as a result of *your* failure to comply with *GMS'* option to return *you* to *your province of residence* for further medical *treatment*; or
4. *you* reach the maximum *trip* length allowable under the plan option chosen.

Out-of-Canada travel coverage requires *you* to return to Canada when *you* reach the maximum *trip* length allowable under the plan before benefit coverage will be provided for subsequent *trips*.

You must maintain valid government health insurance for coverage to be valid. To do this *you* must ensure that *you* are not outside *your province of residence* for more than the number of days allowable under *your government health plan* in *your province of residence*.

E. Extensions and Policy Changes Applicable to Travel Benefits

Where a *trip* length exceeds the maximum number of days provided by *your* policy, or where *your* age restricts out-of-Canada travel *you* may be eligible to purchase additional coverage through *GMS* TravelStar® Travel Insurance, subject to meeting eligibility and payment of additional premium.

Automatic Extensions

Your travel plan will automatically be extended up to seventy-two (72) hours if the return to *your province of residence* is delayed beyond the expiry date of the coverage due to any of the following.

1. *You* are delayed due to *your* or *your* travelling companion's *medical emergency*. Written confirmation from the attending *physician* is required to verify that *you* are medically unfit to travel. The seventy-two (72) hour extension will begin once *you* have been deemed medically fit to travel or discharged from the *hospital*. In-*hospital* care during the *medical emergency* continues to be covered by *your* policy until *your* discharge from *hospital*.
2. A delay of a common carrier *you* are travelling on causes *you* to miss *your return date* to *your province of residence*.
3. The vehicle *you* are travelling in:
   a. is involved in an *accident*;
   b. has a mechanical breakdown; or
   c. is delayed by a police directed road closure.

Policy Changes

The following policy changes may be done any time prior to departure from *your province of residence*:

1. add or remove *dependants*; and/or
2. upgrade *your* health care plan.

Additional premium may apply and must be paid in full before any policy change will be made.

If *you* require additional travel days after departure from *your province of residence*, *you* may upgrade *your* travel option or purchase top-up coverage through *GMS* TravelStar Travel Insurance.

To upgrade, *you* must not have incurred a claim, required medical *treatment* or anticipate future medical *treatment* during the *policy year*. *You* must contact *GMS* two (2) working days prior to the maximum *trip* length allowable under *your* plan being reached.

F. Managing a Travel *Medical Emergency*

In the event of a *medical emergency*:

1. *You* must contact *GMS* Travel Assistance, where possible, before *you* seek medical *treatment*. *GMS* Travel Assistance will:
   a. offer telephone interpretation services in many languages;
   b. monitor progress during *your medical consultation* and medical *treatment*; and
   c. coordinate all medical *treatment*, transport, and repatriation.

   1.800.459.6604 toll-free (within Canada & US)

   905.762.5196 collect (all other locations)
2. *You* are required to contact *GMS* Travel Assistance within twenty-four (24) hours of receiving medical *treatment* or admission to *hospital*. Failure to do so may limit benefits to the lesser of 70% of *reasonable and customary* expenses or $50,000.

Contacting *GMS* Travel Assistance with a *medical emergency* constitutes a claim regardless of whether payment is made by *GMS* for any related expenses.

G. Making a Travel Claim

In the event of a claim, a claim form must be submitted to *GMS* within ninety (90) days of the illness or injury with the following supporting documentation:

1. original itemized receipts, bills and invoices;
2. proof of payment, if payment was made, by *you* or any other benefit plan;
3. complete medical records including final *diagnosis* by the attending *physician*;
4. proof of travel showing the date *you* departed from and returned to *your province of residence*;
5. *your* historical medical records, as requested by *GMS*;
6. any other relevant documentation that may be requested by *GMS* as required to process a claim in the opinion of *GMS*; and
7. in the case of claims involving *your* death, *GMS* may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

Costs to obtain documents or reports to support *your* claim are not covered.

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Dental Care

These benefits are only available if *you* have purchased the Dental Care option.

A. Dental Care Benefits

GMS will pay the *reasonable and customary* charges up to the maximum provided as shown in the chart below and subject to individual benefit dollar and service limits.

Benefits will begin three (3) months after enrollment in this option and are only available within Canada.

Regardless of limits outlined below, *GMS* will not pay charges in excess of the current *dental fee guide* in *your province of residence*.

	Combined Maximum *(per person, per policy year)*	***GMS* Will Pay**	**Dental Service Classification**
1st year	$500	75%	Basic Dental Service
2nd year	$750	80%	Basic Dental Service
		50%	Major Dental Service
3rd year	$1,000	80%	Basic Dental Service
		50%	Major Dental Service

Basic Dental Services

Subject to the limitations and exclusions stated within this policy, "Basic Dental Services" covers:

1. **Dental exams**
   a. complete exam once every three (3) *policy years*;
   b. limited oral exam procedures; recall and specific exams will be subject to a combined maximum of two (2) exams every *policy year* (emergency exams are unlimited);
2. **Dental x-rays**
   a. one of either a complete series or panoramic x-ray by a *dentist* every three (3) *policy years*
   b. intra-oral and extra-oral x-rays by a *dentist* to a maximum of ten (10) films every two (2) *policy years*;
3. **Diagnostic casts** – once every three (3) *policy years*;
4. ***Treatment* planning and consultation**;
5. **Scaling and planing**
   a. scaling, to a maximum combined with periodontal root planing of ten (10) time *units* every *policy year*;
   b. periodontal root planing, to a maximum combined with scaling of ten (10) time *units* every *policy year*;
6. **Polishing** – two (2) times every *policy year*;
7. **Topical fluoride *treatment*** – two (2) time *units* every *policy year*;
8. **Pit and fissure sealants** – once per tooth per lifetime for dependent children under eighteen (18) years of age;
9. **Protective mouth guards** – one (1) every *policy year* for dependent children under sixteen (16) years of age and one (1) every three (3) *policy years* for adults;
10. **Space maintainers and maintenance** – when a *dentist* has removed a primary tooth and an appliance is used to maintain space for a permanent tooth;
11. **Interproximal disking of teeth**;
12. **Occlusal adjustment and equilibration** – to a maximum of four (4) time *units* every *policy year*;
13. **Basic restorations** – of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations, and plastic restorations;
14. **Endodontic *treatment*** – for permanent teeth including *treatment* of the pulp chamber, root canal therapy, periodontal services, miscellaneous surgical services (root amputation, hemisection, replantation, and perforations), and miscellaneous endodontic procedures (open and drain and non-vital bleaching); root canal therapy is limited to one (1) per tooth every five (5) *policy years*; endodontic re-*treatment* of a previous root canal is limited to one (1) per tooth every five (5) *policy years*;
15. **Non-surgical periodontal services** – including management of oral disease and desensitization;
16. **Surgical periodontal services** – including gingival curettage, gingivoplasty, gingivectomy, and flap approach; each type of surgery is limited to one (1) per site (sextant) every *policy year*;
17. **Removable prosthodontic services** – including denture repairs and additions, tissue conditioning for dentures and miscellaneous denture services (resilient liner and resetting of teeth);
18. **Denture and prosthodontics**
    a. relining and rebasing, once every three (3) *policy years* per arch;
    b. denture remakes, when a replacement partial denture would be eligible for coverage; and
    c. fixed prosthodontics repairs including replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, re-cementation, and fixed bridge/prosthesis repairs;
19. **Basic oral surgery**
    a. including erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions, and post-surgical care; and
    b. anaesthesia;
20. **Dental appliances** – for the control of oral habits including bruxism, excluding dental appliances required to address obstructive sleep apnea, snoring or upper airway resistance syndrome (UARS); one (1) every *policy year* for dependent children under sixteen (16) years of age and one (1) every three (3) *policy years* for adults.

Major Dental Services

Subject to the limitations and exclusions stated within this policy, "Major Dental Services" covers:

1. **Inlays, onlays, crowns, and veneers** – are provided when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where significant areas of previous fillings and decay prevent the use of more traditional filling materials to adequately restore the tooth; replacement when applied to a natural tooth must be separated by at least five (5) *policy years*;
2. **Dentures**
   a. initial complete or partial dentures when additional teeth are extracted while *you* are covered under this plan to a maximum of one (1) per arch;
   b. replacement of complete or partial dentures when additional teeth are extracted while *you* are covered under this plan, or if the existing complete or partial denture is at least five (5) years old; and
   c. denture adjustments, once every *policy year*;
3. **Bridge**
   a. initial bridge pontics and fixed bridge retainers on teeth extracted while *you* are covered under this plan; if there were three or more teeth missing prior to *you* becoming

Dental Care

eligible for coverage under this policy, *GMS* will pay up to the cost of a partial denture only; and

b. replacement bridge pontics and fixed bridge retainers if the existing bridge pontics or fixed bridge retainer is at least five (5) years old.

4. **Implant Supported Appliances**

a. crowns and bridges supported by an implant are covered on teeth extracted while *you* are covered under this plan; if there were three or more teeth missing prior to becoming eligible for coverage uder this policy, *GMS* will pay up to the cost of a partial denture only; and

b. dentures supported by an implant are covered for teeth extracted while *you* are covered under this plan;

c. replacement of crowns, bridges and dentures supported by an implant are provided only when the crown, bridge or denture is at least ten (10) years old.

B. Dental Care Exclusions

In addition to the General Exclusions listed on page 31 the following exclusions and limitations apply to Dental Care benefits:

1. **Continuous Coverage** – coverage must be continuous for Dental Care benefits to be maintained. Upon termination, all Dental Care benefits will cease, including any pre-approved services or treatments.
2. **Expenses not Covered** – *GMS* does not cover expenses associated with:

a. cosmetic purposes;

b. congenital defects, developmental malformations or temporomandibular joint disorders;

c. implants;

d. replacement of lost or stolen dentures; and

e. tissue grafts.

C. Dental Care Conditions

In addition to the General Conditions listed on page 27, the following conditions apply to dental benefits under this policy.

1. **Pre-approval** – services totalling $500 or more must have prior approval from *GMS* before the services begin. If a dental pre-authorization is not submitted prior to commencement of services, benefits otherwise payable, shall be limited to $500 for the services performed.
2. ***Dental Fee Guide*** – *GMS* will pay for services and procedures only to the maximum amounts as provided for in the current *Dental Fee Guide* in *your province of residence*. For Alberta, where no fee guide exists, *GMS* will pay the maximum amounts as provided for in the CLHIA Reimbursement Guide. Any charges over and above the current *Dental Fee Guide* will be *your* responsibility.
3. **Alternative Benefits Clause** – payment by *GMS* will be limited to the most cost effective *treatment* within acceptable dental standards. Should *you* and *your dentist* choose a more expensive *treatment*, *you* are responsible for any additional charges beyond the allowance for the alternative service. Where there is a dispute as to the most cost effective *treatment* within dental standards the determination of *GMS* shall be final.
4. **Prosthetic Devices** – provision of prosthetic devices including complete dentures, partial dentures, fixed bridgework (and crowns that are part of the bridgework) shall not be covered under this policy if the device was ordered or the service for the device was started before the *benefit effective date*.
5. ***Necessary and Adequate*** – the policy covers only *necessary and adequate* dental services. Where there is a dispute as to *necessary and adequate* dental services, the determination of *GMS* shall be final.
6. **Transitional Appliances** – *GMS* will pay for the services required for a permanent appliance deducting any amount paid for a temporary appliance when making the transition within one year of services commencing.
7. **Multiple Restorations** – multiple restorations submitted on the same tooth within twelve (12) months will be limited according to *reasonable and customary* charges as indicated in the current *dental fee guide*. Replacement of identical restorations will only be covered once every twelve (12) months.

Prescription Drugs

These benefits are only available if *you* have purchased the Basic or Enhanced *Prescription Drug* additional coverage option.

A. *Prescription Drug* Benefits

Subject to exclusions set out in this section and the General Exclusions on page 31, *prescription drugs* prescribed in writing by a *physician* will be covered based on the *formulary* in *your province of residence*.

For each eligible *prescription drug you* are responsible to pay a $4 deductible, whether submitted using *your GMS* pay-direct card or by manual submission to *GMS*.

Basic *Prescription Drug* Coverage

Basic drug coverage provides up to a maximum of $3,500 per person per *policy year* for newly prescribed drugs listed in *your* provincial *formulary* unless it is specifically excluded below or related to a *medical condition* which existed prior to *your* application date.

Drugs and costs not covered are:

1. drugs not listed in *your* provincial health *prescription drug* services *formulary*;
2. drugs available without a prescription;
3. *special status* drugs;
4. drugs for *treatment* of pre-existing *medical condition(s)* in which the *prescription drug* was prescribed or taken in the six (6) months prior to applying for *GMS* coverage and/or *prescription drugs* for which refills were authorized at the time *you* applied for *GMS* coverage;
5. drugs intended for the *treatment* of sexual dysfunction;
6. drugs for *treatment* of hair loss or to restore hair growth;
7. experimental drugs;
8. drugs used for the purpose of weight loss;
9. drugs used for cosmetic purposes;
10. vaccines;
11. smoking cessation drugs;
12. contraceptive drugs;
13. self-prescribed drugs or those drugs prescribed by a *family member*;
14. vitamins; and
15. delivery and transportation costs associated with the acquisition of the drug(s).

Enhanced *Prescription Drug* Coverage

Enhanced drug coverage provides up to a maximum of $5,000 per person per *policy year* for newly prescribed drugs, including oral contraceptives, listed in *your* provincial *formulary* unless it is specifically excluded below or related to a *medical condition* which existed prior to *your* application date (does not apply to oral contraceptives).

Drugs and costs not covered are:

1. drugs not listed in *your* provincial health *prescription drug* services *formulary*;
2. drugs available without a prescription;
3. *special status* drugs;

4. drugs for *treatment* of pre-existing *medical condition(s)* in which the *prescription drug* was prescribed or taken in the six (6) months prior to applying for *GMS* coverage and/or *prescription drugs* for which refills were authorized at the time *you* applied for *GMS* coverage;
5. drugs intended for the *treatment* of sexual dysfunction;
6. drugs for *treatment* of hair loss or to restore hair growth;
7. experimental drugs;
8. drugs used for the purpose of weight loss;
9. drugs used for cosmetic purposes;
10. vaccines;
11. smoking cessation drugs;
12. self-prescribed drugs or those drugs prescribed by a *family member*;
13. vitamins; and
14. delivery and transportation costs associated with the acquisition of the drug(s).

$800 per person per *policy year*, which forms part of the $5,000 maximum Enhanced *Prescription Drug* coverage limit, may be used to purchase:

1. *prescription drugs* for *treatment* of pre-existing *medical condition(s)* including *prescription drugs* for which refills were authorized at the time *you* applied for *GMS* coverage;
2. *prescription drugs* not listed under *your* provincial drug *formulary*;
3. *special status prescription drugs*; and
4. *prescription drugs* otherwise not eligible under the $5,000, including but not limited to injectable vitamins, vaccines, and lifestyle drugs.

Drugs and costs not covered by the $800 per person, per *policy year*:

1. drugs available without a prescription;
2. self-prescribed drugs or those drugs prescribed by a *family member*; and
3. delivery and transportation costs associated with the acquisition of the drug(s).

B. *Prescription Drug* Conditions

In addition to the General Conditions listed on page 27, the following conditions apply to *Prescription Drug* benefits under this policy.

1. **Generic Pricing** – payment by *GMS* will be limited to generic pricing when a higher cost drug is dispensed. Brand name drugs will be limited to generic pricing unless 'no substitutions' is specifically indicated on the prescription by the *physician*. *You* are responsible for any additional charges.
2. **Compounding** – prescriptions for compounds must contain an active ingredient in a therapeutic concentration that is an eligible drug under the *prescription drug* benefits.
3. **Pre-approval** – under certain circumstances *prescription drugs* may require pre-approval by *GMS*. For more information contact *GMS*.
4. ***Formulary*** – for provinces that do not have a provincial *formulary*, claims will be adjudicated using the province of Saskatchewan *formulary*.

Hospital Cash

These benefits are only available if *you* have purchased the *Hospital* Cash additional coverage option.

A. *Hospital* Cash Benefit

When *you* are confined to a *hospital* and undergoing active *treatment* on an in-patient basis due to an *accident* or illness, this benefit provides payment per person admitted to *hospital* of $100 per day up to a maximum of $3,000 per *policy year*.

For each *hospital* stay, the benefit is payable as described below:

Reason for hospitalization	*GMS* Will Pay on The
Illness or injury	4th day
Pregnancy, childbirth or pregnancy related *medical condition*	7th day

B. *Hospital* Cash Exclusions

The following exclusions apply to the *Hospital* Cash benefit:

1. **Benefit restrictions** – *Hospital* Cash expenses are not payable if, on the application date *you* were:
   a. hospitalized; or
   b. awaiting or scheduled for in-*hospital* care or surgery.
2. **Cancer** – if *you* were diagnosed with cancer within twenty-four (24) months of the application date, *Hospital* Cash expenses will not be paid for any cancer-related *hospital* stays.
3. **Pregnancy**
   a. *Hospital* Cash expenses resulting from pregnancy or complications due to the pregnancy are not payable if on *your* application date *you* are twenty-one (21) weeks pregnant or more; or
   b. if *you* were less than twenty-one (21) weeks pregnant on the application date, payment under this benefit will be limited to two (2) days of *Hospital* Cash following six (6) days of continuous hospitalization as a result of pregnancy or complications due to the pregnancy.

C. *Hospital* Cash Conditions

In addition to the General Conditions listed on page 27, the following conditions apply to the *Hospital* Cash benefit section under this policy.

1. **Benefit calculation** – in calculating the number of days in respect of coverage, the day of admission and day of discharge shall be counted as one day each.
2. **In Canada** – this benefit is only payable when *you* are hospitalized within Canada.
3. **Claiming** – when making a *Hospital* Cash benefit claim *GMS* requires the official discharge papers from the *hospital* stating the admission and discharge dates, as well as a *diagnosis* by *your physician* in regards to *your* admission to the *hospital*.
4. **Newborn children** – newborn children will not be eligible for the *Hospital* Cash benefits until after they have been released from the *hospital* following birth; they are added to the policy; and the appropriate premiums are paid.

HOW TO MAKE A CLAIM

The following conditions apply when applying for reimbursement of a medical service, supply or *treatment* under any of the Health, *Hospital* Cash, Dental Care, or *Prescription Drug* benefits provided under this policy.

Refer to Managing a Travel *Medical Emergency* and Making a Travel Claim for details on travel reimbursement.

A. Making a Claim

As some benefits require pre-approval by *GMS* or written referrals from qualified *physicians* for coverage to apply, please refer to each benefit for specifics.

1. **Health Benefits Claim** – for reimbursement of a health service, supply or *treatment* charge, *GMS* requires a completed Health Benefit Claim Form, original itemized receipts including *your* name, *GMS* ID number, date and details of service, as well as *physician* referral where indicated.
2. **Dental Care Benefits Claim** – for a dental service, supply or *treatment*, *your dentist* may choose to be paid directly using *your* pay-direct card, or *you* may need to pay and then be reimbursed by submitting *your* claim manually. When submitting *your* claim manually, *GMS* requires a standard dental claim form be completed and submitted including *your* name, *GMS* ID number, address and phone number, date and details of the service(s).
3. ***Prescription Drug* Benefits Claim** – for a *prescription drug*, *your* pharmacist may choose to be paid directly using *your* pay-direct card or *you* may need to pay and then be reimbursed by submitting *your* claim manually. When submitting *your* claim manually, *GMS* requires a completed Health Benefit Claim Form, original itemized receipts including *your* name, *GMS* ID number, address and phone number, date and details of the *prescription drug*(s).
4. ***Hospital* Cash Benefit Claim** – for reimbursement of *Hospital* Cash expenses, *GMS* requires a completed *Hospital* Cash Claim Form, including *your GMS* ID number, and the official discharge papers from the *hospital* stating the admission and discharge dates and a *diagnosis* by *your physician* in regards to *your* admission to the *hospital*.
5. **Ways to Submit *Your* Claim** – claim forms can be obtained online at www.gms.ca. *You* may choose to submit *your* claim in the following ways.
   - Online by logging into *your* My *GMS* Account at www.gms.ca
   - Mailing *your* claim to *GMS* head office in Regina
   - By fax: 1.306.525.6360

   Where original copies of receipts are not supplied to *GMS*, *you* must keep original receipts for a minimum of twelve (12) months after submitting *your* claim request. *GMS* reserves the right to request original copies of receipts.
6. **When a Claim Must be Submitted** – claims must be submitted within twelve (12) months from the date of service and no later than thirty (30) days following the expiry date of the policy.
7. **Payment to Providers** – *GMS* may pay part or all of the benefit directly to the provider of the service upon receipt of *your* written instructions.

GENERAL CONDITIONS

The following general conditions apply to all benefits and *additional coverage options*, including travel, which are detailed under this policy.

1. **Coverage Starts** – coverage is not effective until *GMS* approves the application, and the appropriate premium has been paid.
2. **Maintaining Provincial Health Coverage** – to remain eligible for the benefits provided under this policy *you* must maintain valid provincial health coverage from *your province of residence* while the policy is in effect.
3. **Misrepresentations** – any material misrepresentation, provision of incorrect information, or non-disclosure of information by *you* will result in non-payment of any claim and will void *your* coverage.
4. **Policy Types Available** – enrolment is open to any person on a *single*, *couple* or *family* basis, who has valid health coverage from their *province of residence* and who remains in their *province of residence* for a minimum of one hundred and eighty (180) days of each calendar year.
5. ***Family* Contracts** – a *family* contract provides coverage for up to six individuals consisting of: two parents with up to four eligible *dependants* or one parent and up to five eligible *dependants*.

   Additional family members may be added by contacting *GMS* and paying the applicable premium for each additional *family member* that is to be covered.
6. **Newborns** – *GMS* must be notified within thirty (30) days in order to add a newborn to the policy from their date of birth. If not notified within that time frame, coverage is effective on the date of notification.
7. **Policy Evaluation Period** – *you* have ten (10) days from the day *you* apply for *your* policy to return it to *GMS* for cancellation. The policy will be considered null and void and any premium paid up to the end of the 10-day exam period will be refunded, provided no claim has been incurred. If a claim has been paid, the amount must be repaid to *GMS* less the premium amount immediately before the policy will be deemed null and void. This evaluation period expires ten (10) days after *you* apply for *your* policy and have received a copy of the policy contract. All other requests for termination are subject to the conditions provided for in the Statutory Conditions section.
8. **Upgrading *Your* Plan** – *you* may upgrade *your* health plan option or add additional coverage for dental care, *prescription drugs*, annual travel or *hospital* cash to *your* health plan at any time during the *policy year*, provided satisfactory evidence of health is provided when requested. The additional coverage will be added on to *your* health plan for the remaining term of the *policy year*. Reimbursement for claims for the additional benefits purchased will be prorated for the remaining term of the *policy year*.
9. **Downgrading *Your* Plan** – *you* may downgrade *your* health plan type at time of renewal. Written notice must be sent to *GMS* requesting the change.
10. **Removing Additional Coverage** – *you* may remove *your* additional coverage for dental care, *prescription drugs*, annual travel, or *hospital* cash at time of renewal, provided *you* have maintained coverage for not less than twelve (12) consecutive months prior to the request date. Written notice must be sent to *GMS* requesting the change.
11. **Change Policy Type** – *you* may change from *single* to *couple* or *family* coverage at any time by submitting a written application. A *spouse* or *dependant* may be added at any time upon becoming eligible under the plan by submitting a written application.

12. **Continuing Coverage for Over-age *Dependants*** – *dependants*, who no longer qualify as a *dependant* under the plan, may continue coverage under a separate policy with *GMS* by completing an application within sixty (60) days of when coverage under the current *GMS* policy would no longer apply. The *dependant* will be entitled to the following:
    a. waiting periods will be waived;
    b. *prescription drug* benefits which are continued will not be subject to the pre-existing drug provisions; and
    c. dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan in which they are transferring from.
13. **Continuing Coverage after Life Changes** – *dependants* are eligible for a new *GMS* policy when necessitated as a result of divorce or separation by providing written notice to *GMS* within sixty (60) days of when coverage under the current *GMS* policy would no longer apply. The *dependant* will be entitled to the following:
    a. waiting periods will be waived;
    b. *prescription drug* benefits which are continued will not be subject to the pre-existing drug exclusion; and
    c. dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan which they are transferring from.
14. **Continuing Coverage from Another Insurance Plan** - when applying for a *GMS* policy to replace another insurance plan which offers similar coverage, the application must be received within sixty (60) days of when coverage under your current policy would no longer apply. *You* are entitled to the following:
    a. waiting periods will be waived; and
    b. dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan in which they are transferring from.
15. **Surviving *Spouse* & Dependant Coverage** – in the event of the *policyholder*'s death, *GMS* will automatically continue coverage for the surviving *spouse* and/or *dependant*, unless the policy is terminated in writing by the surviving *spouse*, *GMS* will issue a new policy confirmation renaming the surviving *spouse* as the *policyholder* and *GMS* will provide updated premiums within 60 days of receiving notice of the *policyholder*'s death in writing.
16. **Right to Amend Premium or Terms** – *GMS* reserves the right to individually establish or amend premium rates, benefit provisions and/or terms and conditions upon application or renewal or with thirty (30) days advance notice.
17. **Currency** – all amounts stated in this policy are in Canadian funds.
18. **Laws Applied** – this policy shall be interpreted and construed in accordance with the law of the Province of Saskatchewan and the federal laws of Canada applicable therein.
19. **Subrogation** – if *reasonable and customary* expenses are incurred due to the fault of a third party, *GMS* may take legal action against the person(s) at fault in *your* name to recover these expenses and *you* hereby agree that *GMS* may do so. *You* agree to fully cooperate with *GMS* in any action that might be taken.
20. **Excess Coverage to Other Insurance Plans** – this policy is in excess only of all other insurance plans or amounts recoverable by any other party. If *GMS* pays eligible expenses to *you* and a third party makes payment for those same benefits, *you* are responsible for reimbursing *GMS* the amount previously paid by *GMS*. Benefits are payable only for amounts in excess of what would normally be payable under government plans as they exist as of the *effective date* of this policy. There is no coverage for any benefits of any nature, which were provided by a government plan on the *effective date* of this policy regardless of whether such benefits continue to be provided by a government plan at the time a claim is made.
21. **Duplication of Services** – no benefit will be paid for or provided that is a duplication of any service, allowance or reimbursement supplied by an existing *government health plan* or private plan.
22. **Coordination of Benefits** – in the event that *you* have concurrent insurance from another source(s) in respect of benefits provided under this policy, benefits shall be co-ordinated with *your* other insurer(s) as follows.
    a. All benefits from any *government health plan* shall be determined and recovered first.
    b. *GMS* will pay eligible expenses only in excess of amounts covered by that of other insurer(s), including but not limited to, any employment related plan, extended health care plan, private or provincial vehicle insurance, credit card policy or any other insurance, whether collectible or not.
    c. If, however, the other source(s) of coverage is also "excess only", all benefits shall be determined and recovered from the policies based on the following priority:
        i. any plan not containing a co-ordination of benefits statement; then
        ii. any employment/retirement related plan; then
        iii. any other plan, including *GMS* (In this case, the benefits shall be prorated according to the maximum amounts that would have been payable as the result of the benefit contained under the respective plans. *You* agree that prorated sharing is what was intended when the policy was entered into and that sharing on any other basis including on the basis of independent or several liability and/or equal sharing is not what was intended or agreed to); then
        iv. the private plan (individual plan) where the insured person is covered as a member.
23. **Publicly Funded Support Programs** – when requested by *GMS*, *you* must apply for all publicly funded support programs that exist or may come to exist during the *policy year*.
24. **Payment without Coverage** – if *GMS* determines that there is no coverage for a claim(s) under this policy, notwithstanding that amounts may have been advanced to *you* or on *your* behalf, all amounts so advanced to *you* or on *your* behalf must be repaid by *you* to *GMS* on demand. In such circumstances any payment(s) made by *GMS* will not constitute an acceptance of coverage.
25. **Authorization** – by purchasing this policy *you* are authorizing the following.
    a. *You* authorize any *physician*, health care provider, other person, *hospital* or institution to release to *GMS* and/or its authorized agents, representatives, affiliates or other service providers (collectively "*GMS*") any information covering *your* medical history, symptoms, *treatment*, exam, *diagnosis* and/or services rendered to *you* or any of *your dependants*.
    b. *You* authorize *GMS* to collect, store and use any information which is provided by *you* and any information obtained pursuant to clauses a. and c.
    c. *You* authorize *GMS* to obtain information from, or disclose information to any *government health plan*; the operator of any *hospital*, clinic, or other health facility; a *physician* or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required. This information is intended for the purposes of administering the plan and communicating with *you*.
    d. Subject to legal or contractual restrictions, *you* may (upon reasonable written notice to *GMS*), choose to withdraw *your* consent to the collection, use and disclosure of such information. It is important to note that if *your* consent is withdrawn, *you* will restrict *GMS*' ability to administer *your* plan. Further, if *you* withdraw *your* consent, *GMS* may not be able to offer *you* products and services and *you* will limit *GMS*' ability to pay *your* claim(s).

26. **Right to Designate a Person** – *GMS* reserves the right to restrict or deny *your* right to designate persons to whom insurance money is payable.
27. **Statutory Limitation** – every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act (BC, AB, MB, NS, PE – title of act may vary by jurisdiction), Limitations Act (SK, NF), Limitations Act, 2002 (ON) or other applicable legislation.
28. **Statutory Conditions** – despite any other provision of the policy, the policy is subject to the statutory conditions in the applicable insurance act respecting contracts of *accident* and sickness insurance of the Canadian province where the policy was issued.
29. **Cooperation** – *you* agree to fully cooperate with *GMS* to provide the documentation and authorization required by *GMS* to administer *your* plan, including the assessment of *your* claim(s). Failure to do so with respect to the assessment of *your* claim(s) will result in non-payment of the claim(s), in accordance with the general conditions.
30. **Rights if Premium is Owed** – *GMS* reserves the right to suspend claims reimbursement until such time as payment of premiums in full is received. In the event of non-payment of premiums, *GMS* reserves the right to terminate the policy with notice. Failure to provide payment of a policy renewal offer within one (1) month of the offer will result in *GMS* terminating the policy with notice.
31. **Termination**:
    a. By *you* at anytime, as provided for under Statutory Condition 6, by providing notice to *GMS*. Any unpaid medical expenses after *GMS* receives notice of termination, regardless of the date of service, will not be paid.
    b. By *GMS* anytime, as provided for under statutory condition 6, by providing written notice to *you*. Medical expenses submitted after termination, regardless of the date of service, will not be paid.
    c. After termination:
        i. annual premiums will be refunded on a pro-rated basis of unused days; or
        ii. pre-authorized payments will be stopped for the next scheduled payment when notice is received ten (10) business days prior to the scheduled date. If less than ten (10) days notice is given, and payment is withdrawn, *GMS* will refund the amount within thirty (30) business days.
32. **Restriction to Reapply** – following a termination by the *policyholder*, re-application for a Personal Health Coverage plan, including options, with *GMS* is restricted for a two (2) year waiting period unless one of the following reasons for termination apply:
    a. the new application is medically underwritten before acceptance; or
    b. the original termination was requested for one of the following conditions:
        i. coverage was replaced by a new group health policy, without a lapse;
        ii. coverage was replaced by a new Personal Health policy, without a lapse; or
        iii. termination was requested due to death, separation or divorce from an insured *spouse* and new coverage is applied for with *GMS*, without a lapse.

GENERAL EXCLUSIONS

The following general exclusions apply to all benefits and *additional coverage options*, including travel, which are detailed under this policy.

1. **Risky Activities** – *GMS* does not cover medical expenses resulting from *your* participation in:
    a. professional sport;
    b. speed contests or racing of motorized land, water or air vehicle(s); and/or
    c. an extreme sport, including but not limited to, scuba diving (except when *you* are NAUI, PADI, ACUC or SSI certified), bungee jumping, parachuting, mountaineering, skydiving, participation in a rodeo, hang gliding, acrobatic or stunt flying or participating in a horse race as a jockey.
2. **Self-harm** – *GMS* does not cover any medical expenses resulting from suicide or self-inflicted injuries.
3. **Criminal or Illegal Activity** – *GMS* does not cover any medical expenses resulting directly or indirectly from *your* criminal or illegal acts.
4. **Drugs and Alcohol** – *GMS* does not cover any medical expenses resulting from *your* sickness, injury, or death if at the time of the sickness, injury, or death evidence supports that it was caused by, or in any way contributed to, by the use or abuse of prohibited drugs, alcohol, or any other intoxicant or the misuse of a drug, whether prescribed or not.
5. **Motor Vehicle *Accident*** – *GMS* does not cover any medical expenses resulting from a motor vehicle *accident*, unless not covered by any other policy.
6. **Medically Necessary** – *GMS* does not cover any medical expenses not medically necessary or which are considered by *GMS* to be experimental. *GMS*' opinion is final and binding.
7. **Unapproved *Treatment*** – *GMS* does not cover medical expenses:
    a. that contravene or are prohibited by the provincial laws of *your province of residence* or the federal laws of Canada; and
    b. for services or supplies which are experimental in nature or that is not considered to be effective. *GMS'* opinion is final and binding.
8. **Result of Conflict** - *GMS* does not cover any medical expenses which results from *war*, *terrorism*, or acts of foreign rebellion.
9. **Cosmetic Services** – *GMS* does not cover any charges for medical expenses for cosmetic purposes, except when in connection with reconstructive surgery to repair or replace tissue damaged by disease or bodily injury.
10. ***Government Health Plan*** – *GMS* does not cover any charges for medical expenses or supplies which are payable under any government health insurance plan.

STATUTORY CONDITIONS

Pursuant to the Insurance Act, the relevant statutory conditions which relate to individual health and travel insurance products have been provided below.

1. **The contract**

(1) The application, this policy, any document attached to this policy when issued, and any amendments to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Waiver

(2) The insurer shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the insurer.

Copy of application

(3) The insurer shall, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

2. **Material facts**

No statement made by the insured or person insured at the time of application for this contract shall be used in defence of a claim under or to avoid this contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

5. **Termination by insured**

The insured may terminate this contract at any time by giving written notice of termination to the insurer by registered mail to its head office or chief agency in the province, or by delivery thereof to an authorized agent of the insurer in the province, and the insurer shall upon surrender of this policy refund the amount of premium paid in excess of the short rate premium calculated to the date of receipt of such notice according to the table in use by the insurer at the time of termination.

6. **Termination by insurer**

(1) The insurer may terminate this contract at any time by giving written notice of termination to the insured and by refunding concurrently with the giving of notice the amount of premium paid in excess of the pro rata premium for the expired time.

(2) The notice of termination may be delivered to the insured, or it may be sent by registered mail to the latest address of the insured on the records of the insurer.

(3) The insurer may deliver notice of termination to the insured by personal delivery, regular post (notice by regular post not valid in AB, ON & BC) or registered mail. Where notice is delivered by:

(i) personal delivery, 5 days' notice of termination shall be given which notice shall begin on the date of personal delivery;

(ii) regular post, 10 days' notice of termination shall be given which notice shall begin on the day following the date of mailing of notice; or

(iii) registered mail, 15 days' notice of termination shall be given which notice shall begin on the day following delivery of the registered letter to the insured's address.

7. **Notice and proof of claim**

(1) The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

(a) give written notice of claim to the insurer:

(i) by delivery thereof, or by sending it by registered mail to the head office or chief agency of the insurer in the province; or

(ii) by delivery thereof to an authorized agent of the insurer in the province; not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability;

(b) within 90 days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the insurer such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby, the right of the claimant to receive payment, his age, and the age of the beneficiary if relevant; and

(c) if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such disability.

Failure to give notice of proof

(2) Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the accident or the date a claim arises under the contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

8. **Insurer to furnish forms for proof of claim**

The insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time he may submit his proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

9. **Rights of examination**

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

(a) the claimant shall afford to the insurer an opportunity to examine the person of the person insured when and so often as it reasonably requires while the claim hereunder is pending; and

(b) in the case of death of the person insured, the insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

10. **When moneys payable other than for loss of time**

All moneys payable under this contract, other than benefits for loss of time, shall be paid by the insurer within 60 days after it has received proof of claim.

DEFINITIONS

The following definitions apply to all health plan types and *additional coverage options*.

accident/accidental – a happening due to external, sudden, fortuitous causes beyond *your* control.

alteration – includes any newly prescribed drug, change in drug type or the increase, decrease or discontinuation of a drug and the adjustment (stop and start) in an anticoagulation drug dosage due to surgery within ten (10) days prior to *your effective date*, except:

a. a dosage adjustment for an anti-hypertensive or cholesterol lowering drug:
b. a change from a brand name drug to a generic brand drug of the same dosage;
c. if *you* are taking Coumadin/Warfarin for anticoagulation therapy and are required to have *your* blood levels tested on a regular basis (INR) and *your medical condition* remains unchanged, yet *you* are adjusting the dosage of *your* anticoagulation drug to ensure *your* INR is maintained within therapeutic range as directed by *your physician*(s); or

d. if *you* are taking insulin or oral anti-diabetic drugs for diabetes and are required to have *your* blood levels tested on a regular basis and *your medical condition* remains unchanged, yet *you* are adjusting the dosage of *your* drugs to ensure *your* blood glucose level is maintained within therapeutic range as directed by *your physician*(s).

additional coverage options – Dental Care benefits, *prescription drug* benefits, *Hospital* Cash and Annual Travel benefits.

benefit effective date – the date a benefit becomes effective under this policy, following any waiting periods that may apply.

contracted – describes an agreement entered into where there is reference to a destination, a date and/or the time and place of arrival and/or departure for a *trip*.

couple – consists of two (2) people living in a spousal relationship or a parent and a *dependant*.

dental fee guide – the current dental association fee guide, of *your province of residence*, including amounts listed for licensed specialist services. If *your province of residence* does not have a *dental fee guide* the *dental fee guide* adopted by *GMS* shall apply.

dentist – a person duly licensed to practice general dentistry. For the purpose of this policy, the work of a dental assistant, while under the direction of a *dentist*, and a dental hygienist shall be accepted as services of the *dentist*.

departure date – the day *you* leave *your province of residence*.

dependant(s) – *your spouse* as defined herein and any unmarried child of *you* or *your spouse* (including step-child, adopted child, or a child from whom *you* have been granted custody pursuant to an Order of the Court) who is chiefly dependent upon *you* or *your spouse* for support and maintenance and is:

a. under twenty-one (21) years of age;
b. under twenty-five (25) years of age, if the child is enrolled in at least three (3) classes per semester or sixty percent (60%) of a full course load in a full-time student educational training facility in Canada; or
c. a developmentally or physically disabled child, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the child attaining the ages indicated above to ensure continuing eligibility.

For coverage to be provided to *dependants* 21 years of age and older, or disabled *dependants*, the GMS Over Age Student Dependant Declaration or GMS Over Age Dependant Questionnaire must be completed and submitted, on an annual basis.

diagnosis – as referred to under Annual Travel, refers to the identification of *medical conditions*, illness or injury through investigation or analysis of the signs and symptoms.

effective date – *your* personal health policy will be effective based on the later of the following:

a. the date in which *GMS* has accepted *your* application and *your* payment has been received by *GMS*;
b. the date as chosen by the *policyholder* as indicated on *your* application subject to *GMS'* acceptance of *your* application and receipt of *your* payment; or
c. the date on which the plan renews and which payment has been received by *GMS*.

family – refers to the type of coverage provided for the *policyholder* and two (2) or more eligible *dependants*.

family member – is *your* legal or common-law *spouse*, parent, brother, sister, legal guardian, step-parent, step-child, step-brother, step-sister, grandparent, grandchild, in-law or natural or adopted child.

formulary – those *prescription drugs* that a provincial or territorial government includes in their drug plan *formulary* and for which the government provides cost sharing with its residents. The formularies vary by province and territory.

GMS – Group Medical Services and/or its authorized agents, representatives, affiliates or other service providers, including its travel assistance provider.

government health plan – any plan of insurance provided by or under the administrative control of any government or governmental agency in accordance with any law (other than the Employment Insurance Act of Canada) or any plan providing insurance coverage regulated by any government, including but not limited to health insurance plans, *home* care programs, drug programs and the Workers' Compensation Act of *your province of residence*.

hospital – an institution licensed, accredited or otherwise officially designated as a *hospital* and which is primarily engaged in providing medical, diagnostic and surgical services for the care and *treatment* of sick or injured persons on an in-patient basis; and which has a laboratory, a registered graduate nurse and a *physician* always on duty and an operating room where surgical operations are performed by *physicians*.

In no event shall the term "hospital" or "general active treatment hospital" mean any hospital or institution or part of such hospital or institution licensed or used principally as a clinic, continued care or extended care facility, convalescent facility, rehabilitation centre, rest home, personal care home, nursing home, health spa or treatment centre for drug addiction or alcoholism.

home – a private residence excluding continued care or extended care facility, convalescent home, rehabilitation centre, rest home, personal care home, nursing home, health spa or treatment centre for drug addiction or alcoholism.

medical condition(s) – any irregularities in *your* health such as illness, injury or emotional, psychological or psychiatric conditions:

a. for which *you* received medical *treatment* or *medical consultation*;
b. related to undiagnosed symptoms for which *you* received medical *treatment* or *medical consultation*; and/or
c. related to undiagnosed symptoms which would have caused an ordinary person to seek medical *treatment* or *medical consultation*.

medical consultation – the act of meeting with a *physician* for the purpose of discussing and evaluating signs or symptoms in an effort to diagnose a *medical condition*, illness or injury; or for the purpose of evaluating *your* progress and medical *treatment* of a *medical condition*, illness or injury.

medical emergency – as referred to under travel coverage is a sudden, unexpected, unforeseeable and/or urgent happening that is acute and poses an immediate risk that requires immediate *medical consultation* and/or medical *treatment*. In the case of a *medical emergency* incurred during *your trip*, a *medical emergency* no longer exists when the medical evidence indicates that no further medical *treatment* is required at *your* destination, or indicates *you* are able to return to *your province of residence* for further medical *treatment*.

necessary and adequate – service(s) that is normally required to be performed and is sufficient for the purpose of *treatment* as deemed within the standards of the industry in which the service(s) is rendered.

physician – a duly qualified doctor of medicine entitled under the laws of the province, state or country where the services are rendered to practice medicine and surgery without restriction, but does not include a naturopath, herbalist, or homeopath.

policyholder – a person in whose favour an insurance policy is issued.

policy year – three hundred sixty-five (365) days following the *effective date* of the policy.

prescription drug(s) – a licensed medicine that is regulated by legislation to require a prescription before it can be obtained and which a (DIN) Drug identification Number has been assigned by Health Canada. The term is used to distinguish it from over-the-counter drugs which can be obtained without a prescription. When referring to a *prescription drug* for a specified condition it includes but is not limited to those prescribed for the direct medical *treatment* of the diagnosed condition, the medical *treatment* of the symptoms associated with the diagnosed condition and the prevention of symptoms associated with the diagnosed condition.

province of residence – is the province or territory *you* have declared as *your* permanent residence and *you* reside in for the required number of days outlined by *your* provincial/territorial health care legislation and/or *government health plan* in order to maintain *your* health coverage.

reasonable and customary – charges that are reasonably comparable, as determined by *GMS*, to those normally charged for the applicable goods or services in *your province of residence or* where the goods or services are purchased or received when coverage is provided for under the annual benefit.

return date – the date on which *you* are *contracted* to return to *your province of residence*.

service(s) – *treatment* performed by a licensed health practitioner which is within the scope of practice as defined under its professional association.

single – one (1) person.

special status – those *prescription drugs* that are granted special coverage under *your province of residence* drug *formulary* when a person meets certain criteria as outlined by that drug *formulary*.

spouse – a legal *spouse* by virtue of a religious or civil marriage or a person who has been residing with the *policyholder* continuously for at least one (1) year and who has been maintained and publicly represented by the *policyholder* as the *policyholder's spouse*.

stable – a *medical condition* is *stable* if, during the period of time specified in the policy, *you*:

a. have not received new medical *treatment*;
b. have not been prescribed a new *prescription drug*;
c. have not had a change in medical *treatment*;
d. have not had an *alteration* in a prescribed drug;
e. have not experienced a deterioration in *your* condition;
f. have not experienced new, more frequent or more severe symptoms;
g. have not had or required *medical consultation* to investigate symptoms that remain undiagnosed;
h. have not required in-*hospital* care or a referral to a specialist, including initial follow-up visits, tests or investigations related to the *medical condition* and pending results; and/or
i. do not anticipate further medical *treatment* after departure from *your province of residence*.

sum insured – is the maximum sum payable, which *you* selected at the time of purchase, or which applies automatically to, a given insurance coverage.

treatment – is any medical, therapeutic or diagnostic measure prescribed or recommended by a *physician* or *dentist* in any form including *prescription drugs*, investigative testing, hospitalization, surgery or other prescribed drugs, investigative testing, hospitalization, surgery or other prescribed or recommended action directly referable to the applicable condition, symptom or problem.

terrorism – an act, including but not limited to the use of force or violence and/or the threat thereof, including hijacking or kidnapping, of an individual or group in order to intimidate or terrorize any government group, association or the general public for religious, political or ideological reasons or ends, and does not include any act of *war*, act of foreign enemies, or rebellion.

transportation – as referred to under travel coverage means economy class transport on a common carrier whether by land, air or sea.

trip – as referred to under travel coverage is the entire period of travel *contracted* by *you*.

unit – is the time measured in fifteen (15) minute increments applicable to dental procedures.

war – armed conflict, whether or not *war* has been declared, between nations or factions within a nation.

you or ***your*** – any person who is eligible for coverage for any benefit under this policy.

If your plan includes travel coverage:

Always call the GMS Travel Assistance Centre before you seek medical attention to ensure the best possible medical care and coverage for your expenses. Our Travel Assistance Centre is available 24 hours a day, 7 days a week, to help you obtain medical treatment, coordinate medical care and transportation, verify coverage, and provide foreign language support.

GMS Travel Assistance Centre

toll-free **1.800.459.6604**
(within Canada and the USA)

collect **905.762.5196**
(from all other locations)

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- Multi-Trip Annual Emergency Medical Insurance
- Trip Cancellation & Interruption Insurance
- Baggage Loss, Damage & Delay Insurance
- Coverage for Sports & Computer Equipment

Immigrants & Visitors to Canada

Emergency medical insurance for new arrivals or visitors to Canada—includes helpful assistance to coordinate treatment and care.

StudentPlan

Emergency medical and travel coverage perfect for post-secondary students studying away from home, within Canada or abroad.

Group Benefit Plans

Insured benefit packages specifically designed and priced for businesses of any size.

Group Medical Services
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