



Personal Health Coverage

Saskatchewan

Effective December 15, 2020



Including



LifeWorks
by Morneau Shepell

Helping you
live well.

Choice. Value. Service.

Healthy and happy people create thriving communities, which is why we aim to put wellness first. Our Individual Health plans provide coverage for care that ensures you can live life to it's fullest. We've been extending our trademark combination of choice, value and service for over 70 years, and we're pleased to extend it to you, too.

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

Value. We offer 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 participating pharmacies, dentists, optometrists and health care providers (like physiotherapists and massage therapists), they're 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**.



GMS is committed to protecting the privacy of our customers. We commit to use your information in a responsible manner. To review the GMS privacy policy visit our website at www.gms.ca/privacy-policy.

Personal Health Plan Types

BasicPlan

Emergency medical coverage, with a few extras, at the lowest possible cost. Our BasicPlan covers the essentials *your* provincial health plan doesn't — including air and ground ambulance *services*, preferred *hospital* rooms, acupuncture, naturopath visits and more.

ExtendaPlan®

Our most popular plan. With all the essential benefits of BasicPlan and more, ExtendaPlan also covers physiotherapy, massage therapy, hearing aids, vision care, and a range of medical equipment and supplies.

OmniPlan®

Our most comprehensive benefits package, OmniPlan can help *you* keep *your family* in better health with greater coverage for physiotherapy, massage therapy and vision care.

Additional Coverage Options

Basic Prescription Drug

Coverage for *prescription drugs* listed under *your* provincial drug plan (*formulary*), including birth control.

Enhanced Prescription Drug

Coverage for *prescription drugs* listed under *your* provincial drug plan (*formulary*), including birth control. Up to \$800 of coverage can be used for treating pre-existing *medical conditions* and legal prescriptions for drugs not listed under *your* provincial drug plan (including *special status* drugs).

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*.



Personal Health Plan Types

Summary of Benefits

Benefits	BasicPlan	ExtendaPlan®	OmniPlan®
Vision Care <i>eye exams and frames/lenses</i>	n/a	80% to \$200 per 2 years combined	\$90/ eye exam / 2 years 90% to \$250 / 2 years for Frames / Lenses
Health Practitioners	70% to \$250 combined maximum <i>Acupunturist, Chiropracist/Podiatrist, Naturopath, Dietitian, Osteopath</i>	80% to \$350 combined maximum <i>Acupuncturist, Chiropractor, Chiropracist/Podiatrist, Massage Therapist, Naturopath, Dietitian, Osteopath, Physiotherapist</i>	90% to \$300 maximum per specialty <i>Acupuncturist, Chiropractor, Chiropracist/Podiatrist, Massage Therapist, Naturopath, Dietitian, Osteopath, Physiotherapist</i>
Speech Pathologist/Therapist	\$45 per visit, 5 visits combined	\$45 per visit, 10 visits combined	\$45 per visit, 10 visits combined
Counselling Services <i>Psychologist, Psychotherapist, & Registered Social Worker</i>	n/a	\$65 per visit, 10 visits combined	\$65 per visit, 15 visits combined
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
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
Accidental Dental	\$500 / injury	\$2,000 / injury	\$5,000 / injury
Wheelchairs, Motorized Scooters & Adjustable Beds	\$500 / 5 years	\$750 / 5 years	\$1,000 / 5 years
Prosthetic Appliances	Artificial eyes, limbs, breast prostheses, surgical bras	Artificial eyes, limbs, breast prostheses, surgical bras	Artificial eyes, limbs, breast prostheses, surgical bras
Patient Walkers	80% to \$300 / 5 years	80% to \$300 / 5 years	80% to \$300 / 5 years
LifeWorks	Included	Included	Included
Annual Travel <i>(emergency medical coverage while travelling)</i>	n/a	48 or 63 days, \$500,000 to a \$2,000,000 maximum, out-of-country and out-of-province. Includes \$500,000 of coverage for COVID-19	30 days, \$2,000,000 maximum out-of-country and out-of-province. Includes \$500,000 of coverage for COVID-19

Additional Coverage Options			
Basic Prescription Drug†	Payment up to \$3,500 for newly prescribed drugs, including birth control.	Hospital Cash*	\$100 per day up to a maximum of \$3,000 per policy year.
Enhanced Prescription Drug†	Payment to an overall maximum of \$5,000 for prescribed drugs and birth control. Includes \$800 for pre-existing medications.	Dental Care*	Preventative Care, Basic and Major Services. Year 1 \$500, Year 2 \$750, Year 3+ \$1,000.

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.

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Did you know your GMS ID Card doubles as a pay-direct card? Present your ID card at participating health and vision service providers and they'll bill us directly so you don't have to pay out of pocket. Log into your My GMS account to find a participating provider near you.

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

HEALTH

Claims must be submitted within 12 months from the date of service and no later than 30 days following the *expiry date* of the policy. In addition to the General Conditions listed on page 27, the following conditions apply to the health benefits under the policy.

- 1. Benefits provided by this policy are available when deemed *medically necessary* and provided by a *physician* or licensed health care professional. *GMS* reserves the right to request a referral from *your physician*.
- 2. Reimbursement for goods and *services* purchased will be based on *reasonable and customary* charges up to the maximum amounts set out in each benefit subject to conditions, exclusions and limitations.

A. Health Benefits

1. Vision Care

a. **Eye Exams** – provides payment for eye exams including refractions by a qualified *physician*, optometrist, ophthalmologist. This benefit does not cover eye exams related to surgical procedures or any form of optical surgery.

b. **Frames/Lenses** – provides payment for prescription eyeglasses, sunglasses, and 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* and can be purchased world-wide.

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

OmniPlan®

Eye exams \$90 maximum per person in the 2 most recent *policy years*
Frames/lenses 90% to \$250 maximum per person in the 2 most recent *policy years*

ExtendaPlan®

80% to \$200 combined maximum for eye exams and frames/lenses per person in the 2 most recent *policy years*

- 2. **Health Practitioners** – provides payment for the stated *services* under each plan. All *services* must be provided by a practitioner who is licensed, certified or registered by their provincial regulatory agency, or a registered member of a professional association recognized by *GMS*. *Services* must be rendered by a non-*family member*. This benefit does not cover supplements, diagnostic or investigative testing.

OmniPlan

90% to a maximum of \$300 per health practitioner, per person, per *policy year* for Acupuncturist, Chiropractor, Chiropractist/ Podiatrist, Massage Therapist, Naturopath, Dietitian, Osteopath, and Physiotherapist

ExtendaPlan

80% to a maximum of \$350 combined per person, per *policy year* for Acupuncturist, Chiropractist/ Podiatrist, Naturopath, Dietitian, Osteopath, and Physiotherapist

BasicPlan

70% to a maximum of \$250 combined per person, per *policy year* for Acupuncturist, Chiropractist/ Podiatrist, Naturopath, Dietitian, and Osteopath

3. **Speech Pathologist/Therapist** – provides payment for the *services* of Speech Pathologists or Therapists. All *services* must be provided by a practitioner who is licensed, certified or registered by their provincial regulatory agency, or a registered member of a professional association recognized by *GMS*. *Services* must be rendered by a non-family member. This benefit does not cover diagnostic or investigative testing.

OmniPlan	ExtendaPlan	BasicPlan
Combined maximum of \$45/visit x 10 visits, per person, per <i>policy year</i>	Combined maximum of \$45/visit x 10 visits, per person, per <i>policy year</i>	Combined maximum of \$45/visit x 5 visits, per person, per <i>policy year</i>

4. **Counselling Services** – provides payment for the *services* of Psychologists, Psychotherapists, and Registered Social Workers. All *services* must be provided by a practitioner who is licensed, certified or registered by their provincial regulatory agency, or a registered member of a professional association recognized by *GMS*. *Services* must be rendered by a non-family member. This benefit does not cover diagnostic or investigative testing.

OmniPlan	ExtendaPlan
Combined maximum of \$65/visit x 15 visits per person, per <i>policy year</i>	Combined maximum of \$65/visit x 10 visits per person, per <i>policy year</i>

5. **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 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 5 most recent <i>policy years</i> ; applies to purchase or repair	\$500 maximum per person in the 5 most recent <i>policy years</i> ; applies to purchase or repair

6. **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; | g. lymphedema sleeves; |
| b. air casts; | h. rib belts; |
| c. cervical collars; | i. sacroiliac corsets; |
| d. clavicle straps; | j. shoulder immobilizers; |
| e. cryo cuffs; | k. trusses; and/or |
| f. compression stockings (4 pairs per person, per <i>policy year</i>); | l. wigs and hairpieces required as a result of alopecia, chemotherapy or radiation therapy for temporary or permanent hair loss: 1 per person, per <i>policy year</i> . |

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 combined maximum per person, per <i>policy year</i>	\$500 combined maximum per person, per <i>policy year</i>

7. **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 <i>policy year</i>	\$300 maximum per person, per <i>policy year</i>

8. **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 <i>policy year</i> , to a lifetime maximum of \$2,500 per person	\$500 maximum per person, per <i>policy year</i> , to a lifetime maximum of \$1,500 per person

9. **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 1 per policy in the 5 most recent <i>policy years</i>	Maximum 1 per policy in the 5 most recent <i>policy years</i>

10. **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, chiropractor/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 1 pair per person, in the 3 most recent <i>policy years</i> for adults and 1 pair per person per <i>policy year</i> for children under 16 years of age	80% to a maximum of 1 pair per person, in the 5 most recent <i>policy years</i> for adults and 1 pair per person per <i>policy year</i> for children under 16 years of age



- Register for a My *GMS* account so you can:
- submit claims online,
 - sign up to have claim payments directly deposited into a bank account of your choice,
 - locate health and vision providers near you that accept the *GMS* pay-direct card,
 - review your claims history, and more!

11. **Orthopedic Shoes** – provides payment for the cost of 1 pair of custom-made shoes or the cost to modify 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 ‘cast’ of *your* foot. A ‘cast’ 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 ‘cast’ 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 <i>policy year</i>	\$225 maximum per person, per <i>policy year</i>

12. **Mobility Aids** – provides payment for the purchase of 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 <i>policy year</i>	\$300 maximum per person, per <i>policy year</i>

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

OmniPlan	ExtendaPlan
\$300 maximum per person, per <i>policy year</i>	\$300 maximum per person, per <i>policy year</i>

14. **Ambulance** – provides payment for *medical emergency* transport by licensed professional road ambulance to the nearest *hospital* or health centre equipped to provide *medically necessary treatment* for in-patient and/or 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 <i>policy year</i>

15. **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*.

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

OmniPlan	ExtendaPlan	BasicPlan
Unlimited	Unlimited	Unlimited

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

OmniPlan	ExtendaPlan	BasicPlan
Unlimited	Unlimited	Unlimited

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

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

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum 45 days per person, per <i>policy year</i> , to an overall maximum of \$3,500 per person per <i>policy year</i>	\$1,000 maximum per person, per <i>policy year</i>	\$500 maximum per person, per <i>policy year</i>

18. **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.

This 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 <i>policy year</i> ; includes in- <i>hospital</i> and in- <i>home</i> care	80% to \$3,000 maximum per person, per <i>policy year</i> ; includes in- <i>hospital</i> and in- <i>home</i> care	80% to \$1,500 maximum per person, per <i>policy year</i> ; includes in- <i>hospital</i> care only

19. **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 6 months from the date of injury. All *treatment* must be completed within 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

20. **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*.

This 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 combined maximum per person, per policy year in the 5 most recent <i>policy years</i>	\$750 combined maximum per person, per policy year in the 5 most recent <i>policy years</i>	\$500 combined maximum per person, per policy year in the 5 most recent <i>policy years</i>

21. **Prosthetic Appliances** – provides payment for the purchase of artificial limbs, artificial eyes, breast prostheses and surgical bras (2 per person, per policy year) as a result of surgery. This benefit does not cover myoelectric limbs.

OmniPlan	ExtendaPlan	BasicPlan
Included	Included	Included

22. **Patient Walkers** – provides payment for 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 year in the 5 most recent <i>policy years</i>	80% to \$300 maximum per person, per policy year in the 5 most recent <i>policy years</i>	80% to \$300 maximum per person, per policy year in the 5 most recent <i>policy years</i>

23. **LifeWorks by Morneau Shepell** – provides *you* and *your dependants* with wellness services to help improve *your* mental, physical, financial and social wellbeing. *You* and *your dependants* have access to the following:

Assistance Program – 24/7 access to short-term confidential professional services and referrals to community resources for a broad range of personal and *family* challenges including:

- marital or *family* relationship concerns;
- personal or work-related stress;
- elder or child care;
- alcohol or drug abuse;
- coping with grief;
- financial or legal difficulties; and
- career counselling.

Your assistance program can be accessed anytime by calling 1.833.347.7289 or online by logging into *your* My *GMS* account. Select Policies on the right-hand side of the screen to access the link to LifeWorks.

Wellness Program – inspiration to proactively make positive health and lifestyle changes with:

- tools and personalized recommendations to keep *you* on track;
- assessments to better understand *your* mental, physical, social and financial wellbeing;
- personal challenges to build better habits for nutrition, weight management, financial wellbeing, etc;
- perks that include exclusive offers, discounts and online cashback from over 1,200 major brands.

Your wellness program can be accessed online at <https://groupmedicalservices.lifeworks.com> or through the LifeWorks app. To create *your* wellness account, follow these instructions:

- select the blue “Sign-Up” button on-screen.
- enter *your* invitation code which is *your* *GMS* ID number (make sure *you* enter *GMS* and a dash symbol before *your* *GMS* ID number).
- follow the on-screen instructions.

Please note: once *your* profile is set up, use *your* email address and password to login.



OmniPlan	ExtendaPlan	BasicPlan
Included	Included	Included

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With *your* LifeWorks account, *you* have access to a wealth of online resources to support *your* wellbeing, including articles, podcasts, infographics and toolkits. Login today to get started!

ANNUAL TRAVEL COVERAGE

(included in OmniPlan® and ExtendaPlan®)

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



GMS Travel Assistance is available 24/7. In the event of a travel medical emergency, contact us as soon as possible so we can support you through your emergency.

Call toll-free 1.800.459.6604 (within Canada & US) or collect 905.762.5196 (from all other locations).

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.

	OmniPlan	ExtendaPlan		
		Option 1	Option 2	Plus
Number of days per <i>trip</i> outside of Canada†	30 days	48 days	48 days	63 days
Number of days per <i>trip</i> inside of Canada	183 days	183 days	183 days	183 days
Maximum aggregate limit per person, per year	\$2,000,000	\$500,000	\$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/territory of residence*, unless otherwise stated, *GMS* will pay *reasonable and customary* expenses on *your* behalf:

1. up to the maximum provided by the plan option *you* have chosen; and
2. up to \$500,000 CAD, which forms part of the maximum provided by the plan option *you* have chosen, in the event of a positive *diagnosis* of COVID-19 while on *your trip*, even if a travel advisory to “Avoid non-essential travel” is in place exclusively due to COVID-19.

Where a listed benefit indicates a maximum limit, the limit is applied per person, per *policy year*.

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 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 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/territory 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/territory 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 1 accompanying *family member* insured under *your* policy to *your province/territory of residence* when:
 - a. *GMS* requires that *you* return to *your province/territory 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 18 to *your province/territory of residence* when *you* have been returned to *your province/territory 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 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/territory 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/territory 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/territory 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/territory of residence*, when *you* have been returned to *your province/territory 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. 90 days for all individuals who were 69 years of age and

- younger as of the *effective date* of this policy;
- b. 180 days for all individuals who were age 70 and older as of the *effective date* of this policy; or
- c. 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;
 - 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/territory 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/territory of residence when deemed medically necessary.
Refusal to comply with a transfer request or a request to return to your province/territory of residence, when you could have been returned to your province/territory of residence without endangering your life or health, even if the treatment available in your province/territory of residence could be of lesser quality than the treatment available outside your province/territory 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 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 where:
 - a. Before your departure, an official travel advisory is issued by the Canadian government, stating "Avoid non-essential travel" or "Avoid all travel" for the country, region, city or other destination (including cruise ship) that include part of your travel arrangements.
 - b. This exclusion does not apply when the "Avoid non-essential travel" warning is related to COVID-19.

To view the travel advisories, visit the Government of Canada Travel site: <http://travel.gc.ca/travelling/advisories>.
 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 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 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/territory 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/territory of residence or outside Canada.

6. **Purchase Requirement** – the travel benefit must have been purchased prior to *your* departure from *your province/territory 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/territory 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/territory 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/territory of residence*;
2. *GMS* returns *you* to *your province/territory 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/territory 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*.

Out-of-Province travel coverage requires *you* to return to *your province/territory of residence* when *you* reach the maximum *trip* length allowable under the plan before *your* 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/territory of residence* for more than the number of days allowable under *your government health plan* in *your province/territory 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 72 hours if the return to *your province/territory of residence* is delayed beyond the travel coverage end date 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 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/territory 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/territory 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/territory 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* 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 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 90 days of the illness or injury with the following supporting documentation:

1. original itemized receipts, bills and invoices;

- proof of payment, if payment was made, by *you* or any other benefit plan;
- complete medical records including final *diagnosis* by the attending *physician*;
- proof of travel showing the date *you* departed from and returned to *your province/territory of residence*;
- your* historical medical records, as requested by *GMS*;
- any other relevant documentation that may be requested by *GMS* as required to process a claim in the opinion of *GMS*; and
- 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.

ADDITIONAL COVERAGE OPTIONS

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

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

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 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/territory 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:



Don't forget your *GMS Pay-Direct* card when you visit the dentist. You can show your card at participating dentists and they'll bill us. No need for you to pay out of pocket.

- Dental exams**
 - complete exam once every 3 *policy years*;
 - limited oral exam procedures; recall and specific exams will be subject to a combined maximum of 2 exams every *policy year* (emergency exams are unlimited);
- Dental x-rays**
 - one of either a complete series or panoramic x-ray by a *dentist* every 3 *policy years*
 - intra-oral and extra-oral x-rays by a *dentist* to a maximum of 10 films every 2 *policy years*;
- Diagnostic casts** – once every 3 *policy years*;
- Treatment planning and consultation**;
- Scaling and planing**
 - scaling, to a maximum combined with periodontal root planing of 10 time *units* every *policy year*;
 - periodontal root planing, to a maximum combined with scaling of 10 time *units* every *policy year*;
- Polishing** – 2 time *units* every *policy year*;
- Topical fluoride treatment** – 2 time *units* every *policy year*;
- Pit and fissure sealants** – once per tooth per lifetime for dependent children under 18 years of age;
- Protective mouth guards** – 1 every *policy year* for dependent children under 16 years of age and 1 every 3 *policy years* for adults;
- Space maintainers and maintenance** – when a *dentist* has removed a primary tooth and an appliance is used to maintain space for a permanent tooth;
- Interproximal diskling of teeth**;
- Occlusal adjustment and equilibration** – to a maximum of 4 time *units* every *policy year*;
- Basic restorations** – of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations, and plastic restorations;
- 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 1 per tooth every 5 *policy years*; endodontic re-treatment of a previous root canal is limited to 1 per tooth every 5 *policy years*;
- Non-surgical periodontal services** – including management of oral disease and desensitization;
- Surgical periodontal services** – including gingival curettage, gingivoplasty, gingivectomy, and flap approach; each type of surgery is limited to 1 per site (sextant) every *policy year*;
- Removable prosthodontic services** – including denture repairs and additions, tissue conditioning for dentures and miscellaneous denture services (resilient liner and resetting of teeth);
- Denture and prosthodontics**
 - relining and rebasing, once every 3 *policy years* per arch;
 - denture remakes, when a replacement partial denture would be eligible for coverage; and
 - fixed prosthodontics repairs including replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, re-cementation, and fixed bridge/prosthesis repairs;
- Basic oral surgery**
 - including erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions, and post-surgical care; and
 - 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); 1 every *policy year* for dependent children under 16 years of age and 1 every 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 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 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 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 3 or more teeth missing prior to *you* becoming 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 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 3 or more teeth missing prior to becoming eligible for coverage under 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 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/territory of residence. 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 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 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/territory 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 including birth control 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:



If you're planning to have treatment that costs over \$500, ask your dentist to send us an estimate first. That way we can let you know ahead of time what's covered and avoid any unwanted surprises.

- 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 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. fertility drugs;
- 14. non-hormonal birth control;
- 15. vitamins; and
- 16. 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 birth control, 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 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. fertility drugs;
- 14. non-hormonal birth control;
- 15. vitamins; and
- 16. 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 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 21 weeks pregnant or more; or
 - b. if *you* were less than 21 weeks pregnant on the application date, payment under this benefit will be limited to 2

days of *Hospital Cash* following 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. **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.

D. Hospital Cash Benefit Claims

GMS requires a completed Hospital Cash Claim Form with official discharge papers from the hospital stating the admission and discharge dates.

The Hospital Cash Claim form is online at <https://www.gms.ca/health-dental-claims>; attach your official discharge papers and mail to *GMS* head office in Regina.

HOW TO MAKE A CLAIM

The following information applies to making a claim for reimbursement of a medical *service*, supply or *treatment* under any of the Health, Dental Care, or *Prescription Drug* benefits provided under this policy.

For travel reimbursement refer to Managing a Travel Medical Emergency and Making a Travel Claim on Page 19.

To make a *Hospital Cash* claim refer to section D. *Hospital Cash* on Page 26.

1. **Self-service online** – To make things quick, convenient and easy, register for a My *GMS* account at www.gms.ca to:
 - submit *your* claims online and attach copies of *your* receipts;
 - sign up to have *your* claim payments directly deposited into *your* bank account;
 - view and print *your* personal claim statements;
 - access *your* *GMS* ID numbers;
 - access a copy of this contract;
 - find eligible health care service providers near *you*; and
 - access LifeWorks.
2. **Provider submit** – To avoid paying out of pocket, present *your* pay-direct card for *prescription drugs* at the pharmacy and at *your* dentist for all dental *services*. For other health care provider claims, check our provider search tool at www.gms.ca/provider-locator to help *you* locate vision care providers, chiropractors, massage therapists and physiotherapists near *you*.
3. **Other options** – claim forms are available for download at <https://www.gms.ca/health-dental-claims>. Complete the form, attach *your* itemized receipts and mail to *GMS* head office in Regina. For submitting your dental claim manually, *GMS* requires a Standard Dental Claim Form to be completed by your dentist with your *GMS* ID number.
4. **When a Claim Must be Submitted** – claims must be submitted within 12 months of the date of service and no later than 30 days following the *expiry date* of the policy.

GENERAL CONDITIONS

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

1. **Eligibility Requirements** – to be eligible to purchase, and continue to be eligible for coverage under this policy:
 - a. *You* must be 18 years of age and a resident of Canada;
 - b. *You* must be covered under provincial health insurance; and
 - c. Any person(s) on the policy must be related to *you* in one of the following ways:
 - Legally married to *you* or in a civil union;
 - Living with *you* in a conjugal relationship and presented as *your spouse* or partner; or
 - A child born to *you*, adopted by *you*, or a step child, who is unmarried and entirely dependent on *you* for maintenance and support and who is also:
 - i. Under 21 years of age;
 - ii. Under 25 years of age and attending a college or university full time;
 - iii. Physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on *you* while eligible under i) or ii).

It is your responsibility to tell us when an insured person no longer meets the eligibility requirements.
2. **Coverage Starts** – coverage is not effective until *GMS* approves the application, and the appropriate premium has been paid.
3. **Medical Supplies** – medical supplies can be purchased anywhere within Canada, unless otherwise stated.
4. **Health Services** – health *services* can be provided anywhere within Canada unless otherwise stated.
5. **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.
6. **Family Contracts** – a *family* contract provides coverage for up to 6 individuals consisting of: 2 parents with up to 4 eligible *dependants* or 1 parent and up to 5 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.
7. **Lifestyle Changes** – *You* may change from single to couple or family coverage at any time. A spouse or dependant may be added at any time upon becoming eligible under the plan by submitting an application and meeting the eligibility requirements. *GMS* must be notified within 30 days of birth 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 application approval.
8. **Policy Evaluation Period** – *you* have 10 days from the day *you* receive *your* policy confirmation to cancel without penalty. The policy will be considered null and void and any premium paid up to the end of the 10-day evaluation 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 before the policy will be deemed null and void. All other requests for termination are subject to the conditions provided for in the Statutory Conditions section.
9. **Changes to your plan**
 - a. *You* may upgrade *your* health plan option or add additional coverage for dental care, *prescription drugs* 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 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*.
- You* may downgrade *your* health plan option at time of renewal by notifying *GMS* of *your* request.
 - You* may remove *your* additional coverage for dental care, *prescription drugs*, or *hospital cash* at time of renewal, provided *you* have maintained coverage for not less than 12 consecutive months prior to the request date.
- Written notice must be sent to *GMS* requesting the change.
- 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 60 days of when coverage under the current *GMS* policy would no longer apply. The *dependant* will be entitled to the following:
 - waiting periods will be waived;
 - prescription drug* benefits which are continued will not be subject to the pre-existing drug provisions; and
 - 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.
 - 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 60 days of when coverage under the current *GMS* policy would no longer apply. The *dependant* will be entitled to the following:
 - waiting periods will be waived;
 - prescription drug* benefits which are continued will not be subject to the pre-existing drug exclusion; and
 - 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.
 - 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 60 days of when coverage under *your* current policy would no longer apply. *You* are entitled to the following:
 - waiting periods will be waived; and
 - 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.
 - Surviving Spouse & Dependant Coverage** – in the event of the *policyholder's* death, *GMS* will automatically continue coverage as long as premiums remain paid 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.
 - 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 30 days advance notice.
 - Currency** – all amounts stated in this policy are in Canadian funds.
 - 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.

- 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.
- 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.
- 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.
- 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.
 - All benefits from any *government health plan* shall be determined and recovered first.
 - 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.
 - 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:
 - any plan not containing a co-ordination of benefits statement; then
 - any employment/retirement related plan; then
 - 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
 - the private plan (individual plan) where the insured person is covered as a member.
- 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*.
- 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.
- Authorization** – by purchasing this policy *you* are authorizing the following.
 - 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).
24. **Right to Designate a Person** – *GMS* reserves the right to restrict or deny *your* right to designate persons to whom insurance money is payable.
25. **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.
26. **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.
27. **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.
28. **Grace Period** – The grace period is 30 days for the payment of premiums for customers paying annually. If paying by pre-authorized debit the 30 day grace period is allowed for each premium except for the first month. During the grace period, coverage remains in force and premiums continue to be payable by *you*. Payment of claims will be suspended until payment of premiums has been paid. We will terminate the policy if payment has not been made before the end of the grace period. We will send *you* written notice of termination. Any claims for expenses incurred after the policy has terminated are not eligible for payment.
29. **Premiums** – are due on the date shown on the policy confirmation or renewal notice. If paying by pre-authorized debit *your* policy will auto renew. The premium is determined according to the oldest insured person and the province in which *you* live. If a change in age puts *you* into a different age rate category, premiums are adjusted at the next *policy year*. If *you* move provinces, premiums are adjusted according to the rates of the new province and are effective on the date of the change.
30. **Termination:** *You* or *GMS* may terminate *your* policy at any time by providing written notice as provided under Statutory Condition 3. Medical expenses submitted after termination, regardless of the date of service, will not be paid. After

termination, annual premiums will be refunded on a pro-rated basis of unused days; or pre-authorized payments will be stopped for the next scheduled payment when notice is received 10 business days prior to the scheduled date. If less than 10 business days notice is given, and payment is withdrawn, *GMS* will refund the amount within 30 business days.

31. **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 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/territory 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 on 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.
- (2) The insurer shall, on request, provide 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 a person insured at the time of application for the contract may be used in defence of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers provided as evidence of insurability.

3. Termination of insurance

- (1) The contract may be terminated:
 - (a) by the insurer giving to the insured 15 days' notice of termination by registered mail or 5 days' written notice of termination personally delivered; or
 - (b) by the insured at any time on request.
- (2) If the contract is terminated by the insurer:
 - (a) the insurer must refund the excess of premium actually paid by the insured over the prorated premium for the expired time, but in no event may the prorated premium for the expired time be less than any minimum retained premium specified in the contract; and
 - (b) the refund must accompany the notice.
- (3) If the contract is terminated by the insured, the insurer must refund as soon as is practicable the excess of premium actually paid by the insured over the short rate premium calculated to the date of receipt of the notice according to the table in use by the insurer at the time of termination.
- (4) The 15-day period mentioned in clause (1)(a) of this condition starts to run on the day following the day the registered letter or notification of it is delivered to the insured's postal address.

4. 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, must:
 - (a) give written notice of claim to the insurer not later than 30 days after the date a claim arises under the contract on account of an accident, sickness or disability:
 - (i) by delivery of the notice, or by sending it by registered mail, to the head office or chief office of the insurer in the province/territory; or
 - (ii) by delivery of the notice to an authorized agent of the insurer in the province/territory;
 - (b) within 90 days after the date a claim arises under the contract on account of an *accident*, sickness or disability, provide to the insurer such proof as is reasonably possible in the circumstances of:
 - (i) the happening of the accident or the start of the sickness or disability;

- (ii) the loss caused by the accident, sickness or disability;
- (iii) the right of the claimant to receive payment;
- (iv) the claimant's age; and
- (v) if relevant, the beneficiary's age; and
- (c) if so required by the insurer, provide a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim is made under the contract and, in the case of sickness or disability, its duration.

- (2) Failure to give notice of claim or provide proof of claim within the time required by this condition does not invalidate the claim if:

- (a) the notice or proof is given or provided as soon as is reasonably possible, and not later than the limitation period set out in The Limitations Act after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or provide the proof in the time required by this condition; or
- (b) in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or provided no later than the limitation period set out in The Limitations Act after the date a court makes the declaration.

5. Insurer to provide forms for proof of claim

The insurer must provide forms for proof of claim within 15 days after receiving notice of claim, but if the claimant has not received the forms within that time the claimant may submit his or her 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.

6. Rights of examination

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

- (a) the claimant must give the insurer an opportunity to examine the person insured when and as often as it reasonably requires while a claim is pending;
- (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; and
- (c) the insurer shall bear the costs of any examination or autopsy and shall provide copies of reports of any examination or autopsy to the insured or the insured's representative.

7. When moneys payable other than for loss of time

All money payable under the contract, other than benefits for loss of time, must 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 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, and *Hospital Cash* 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 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/territory of residence*, including amounts listed for licensed specialist services. If *your province/territory 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/territory 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:

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

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:

- the date in which *GMS* has accepted *your* application and *your* payment has been received by *GMS*;
- 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
- the date on which the plan renews and which payment has been received by *GMS*.

expiry date – the last day of *your policy year*.

family – refers to the type of coverage provided for the *policyholder* and 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/territory of residence*.

GMS Travel Assistance – the assistance service which has been appointed by *GMS* to perform all assistance *services* where indicated under this policy.

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 – a disease, illness or injury including symptoms of undiagnosed conditions.

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 – a sudden and unforeseen *medical condition* that requires immediate medical *treatment*. In the case of an emergency incurred during *your trip*, a *medical emergency* no longer exists when the evidence reviewed by *GMS* Travel Assistance indicates that no further medical *treatment* is required at destination or *you* are able to return to *your province/territory of residence* for further medical *treatment*.

medically necessary – means a *treatment*, service or supply which is generally accepted by the medical profession as essential, effective and appropriate in the care and *treatment* of a *medical condition*, sickness or injury.

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 – 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/territory 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 the particular area where the goods or *services* are purchased or received.

return date – the date on which *you* are *contracted* to return to *your* province/territory 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 – 1 person.

special status – those *prescription drugs* that are granted special coverage under *your* province/territory 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 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/territory 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 – a procedure prescribed, performed or recommended by a *physician* for a *medical condition*. This includes but is not limited to prescribed medication, investigative testing and surgery.

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 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.

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