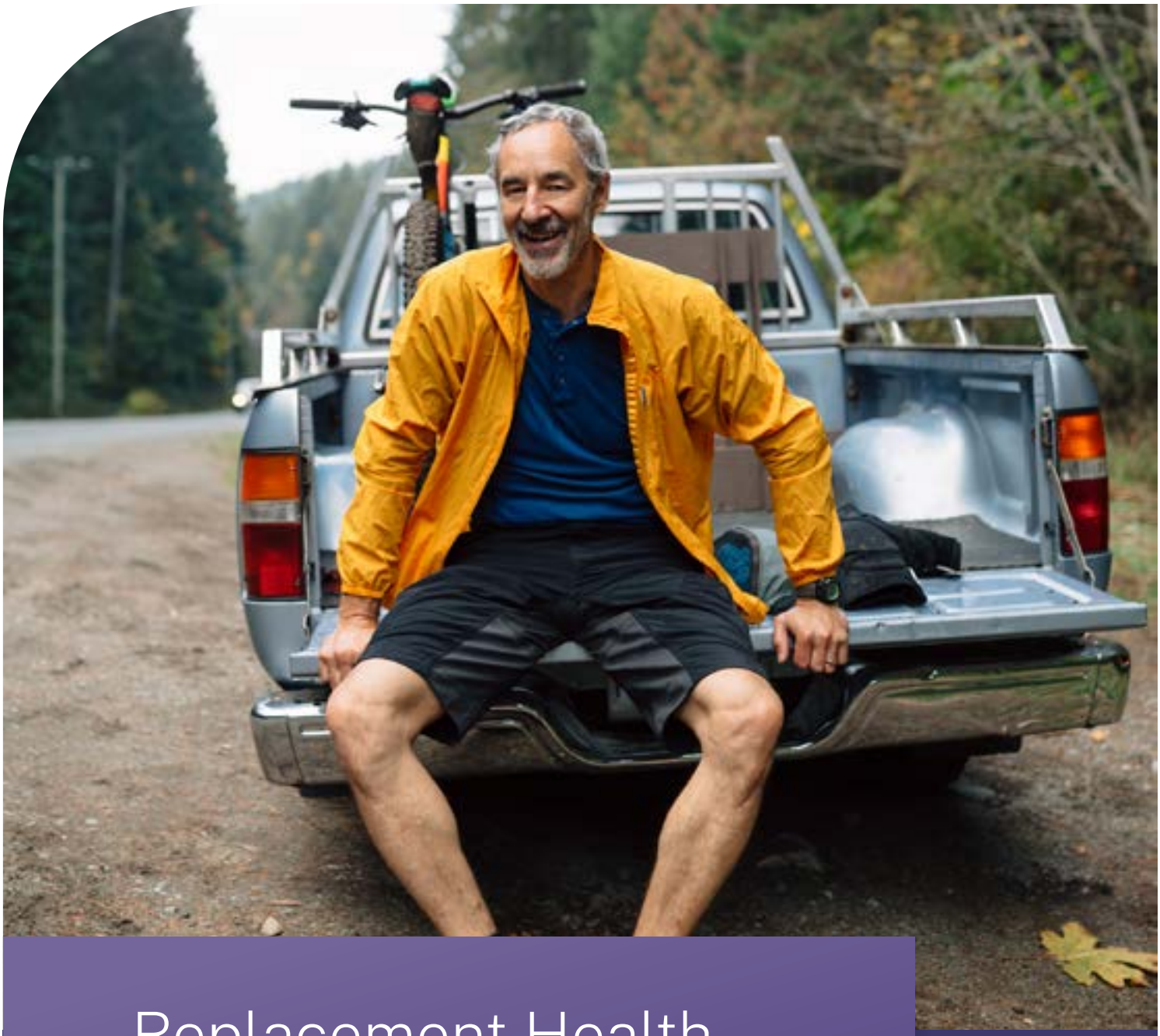

Replacement Health Coverage

EFFECTIVE APRIL 1, 2024

gms health insurance

Policy Wording Contents

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

Replacement Health Schedule of Benefits

Benefits	PremierPlan	ChoicePlan®	EssentialPlan®
Prescription Drugs	up to 80% to $2,500/year	up to 80% to $1,250/year	n/a
Dental Care	80% preventative & basic 50% major $1,500 combined maximum	80% preventative & basic 50% major $1,250 combined maximum	80% preventative & basic 50% major $1,000 combined maximum
Accidental Dental	$2,000 / injury	$2,000 / injury	$2,000 / injury
Private Duty Nursing	80% to $5,000	80% to $3,000	80% to $1,000
Private & Semi-Private Hospital Accommodations	80% to $10,000 combined maximum	80% to $5,000 combined maximum	80% to $2,000 combined maximum
Orthopedic Shoes & Custom Made Foot Orthotics	$300	$300	$300
Health Practitioners (acupuncturist, chiropractor, chiropodist/podiatrist, massage therapist, naturopath, speech therapist and physiotherapist)	100% to $600 combined maximum	80% to $600 combined maximum	50% to $600 combined maximum
Counselling Services (clinical psychologist, clinical counsellor, registered social worker, psychotherapist)	$65/visit x 10 visits combined	$65/visit x 10 visits combined	$65/visit x 5 visits combined
Vision Care (eye wear and eye exams)	$300/ 2 years combined maximum, including 1 eye exam / 2 years	$150/ 2 years combined maximum, including 1 eye exam / 2 years	$100/ 2 years combined maximum, including 1 eye exam / 2 years
Hearing Aids	$800 / 5 years	$500 / 5 years	$500 / 5 years
Ambulance (road and air)	Unlimited	Unlimited	Unlimited
Medical Equipment & Supplies (including but not limited to blood pressure monitors, casts, compression stockings, crutches, mastectomy/ surgical bras, mobility aids and walkers)	$3,000 combined maximum $2,500 lifetime limit on sleep apnea machine	$3,000 combined maximum $2,500 lifetime limit on sleep apnea machine	$3,000 combined maximum $2,500 lifetime limit on sleep apnea machine
Wheelchairs, Motorized Scooters & Hospital Beds	80% to $10,000 combined lifetime maximum	80% to $10,000 combined lifetime maximum	80% to $10,000 combined lifetime maximum
Artificial Limbs, Eyes & Larynx (includes myoelectric limbs)	$10,000 combined lifetime maximum	$10,000 combined lifetime maximum	$10,000 combined lifetime maximum
Breast Prosthesis	$325 single / 2 years $650 bi-lateral / 2 years	$325 single / 2 years $650 bi-lateral / 2 years	$325 single / 2 years $650 bi-lateral / 2 years
Annual Travel (emergency medical coverage while travelling)	15 days out of Canada 183 days within Canada 90-day stability age 69 and under 180-day stability age 70+ Out-of-Canada travel ends at age 80 $1,000,000 lifetime maximum	7 days out of Canada 183 days within Canada 90-day stability age 69 and under 180-day stability age 70+ Out-of-Canada travel ends at age 80 $1,000,000 lifetime maximum	n/a

This is a summary of benefits only. Please refer to the policy wording for complete details. It is important that you read and understand your policy as your coverage may be subject to certain exclusions or limitations.

Policy Wording

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

All claims, with the exception of Travel, must be submitted within 12 months from the date of *service* and no later than 30 days following the *expiry date* of the policy.

Claim eligibility is based on the maximum amounts set out in each benefit and subject to the conditions, exclusions and limitations as outlined in each coverage section and listed in the policy General Conditions and General Exclusions.

A. HEALTH

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*.

A.1. Benefits

1. **Ambulance** – provides payment for emergency transport by a licensed professional ambulance and for emergency transport by a licensed professional air ambulance to the nearest *hospital* equipped to provide the necessary emergency in-patient and out-patient *treatment*.

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

PremierPlan	**ChoicePlan**	**EssentialPlan**
Unlimited	Unlimited	Unlimited

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

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

PremierPlan	**ChoicePlan**	**EssentialPlan**
80% to $10,000 per person, per *policy year*	80% to $5,000 per person, per *policy year*	80% to $2,000 per person, per *policy year*

3. **Vision Care**

   Eye Exams – provides payment for an eye exam by a qualified *physician*, optometrist, or ophthalmologist, to measure the visual acuity of the patient.

   Lenses/Frames/Contacts – provides payment for prescription lenses, frames, contact lenses, post-surgical lenses and/or corrective laser eye surgery.

PremierPlan	**ChoicePlan**	**EssentialPlan**
$300 combined maximum every two years, including one eye exam every two years	$150 combined maximum every two years, including one eye exam every two years	$100 combined maximum every two years, including one eye exam every two years

4. **Health Practitioners** – provides payment for the stated *services* under the Schedule of Benefits. 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*.

PremierPlan	**ChoicePlan**	**EssentialPlan**
100% to a maximum of $600 per person, per *policy year*	80% to a combined maximum of $600 per person, per *policy year*	50% to a combined maximum of $600 per person, per *policy year*

5. **Counselling Services** – provides payment for the stated *services* under the Schedule of Benefits. 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*.

PremierPlan	**ChoicePlan**	**EssentialPlan**
$65 per visit, up to ten visits per *policy year*	$65 per visit, up to ten visits per *policy year*	$65 per visit, up to five visits per *policy year*

6. **Hearing Aids** – provides payment for repair of, or for purchase of a new, hearing aid when prescribed by and/or fitted by an audiologist or as legislated in the insured person's province of residence.

PremierPlan	**ChoicePlan**	**EssentialPlan**
$800 maximum per person in the five most recent *policy years*	$500 maximum per person in the five most recent *policy years*	$500 maximum per person in the five most recent *policy years*

7. **Medical Equipment & Supplies** – provides payment for the purchase or rental of medical equipment and supplies listed in the table below.

   Medical supplies and equipment must be prescribed by a *physician* for personal use in the *home*.

   The items listed in the table are available under this coverage based on the amount shown for each item, per person, per *policy year* subject to the annual combined maximum unless otherwise stated.

PremierPlan	**ChoicePlan**	**EssentialPlan**
$3,000 combined annual maximum per person per *policy year*	$3,000 combined annual maximum per person per *policy year*	$3,000 combined annual maximum per person per *policy year*

Equipment & Supplies	$3,000 Combined Annual Maximum
Blood Pressure Monitors	1/ family/ 5 policy years
Compression Stockings	4 pairs/ policy year
Diabetic Supplies & Equipment (including insulin pumps and testing devices)	$500
Mastectomy/Surgical Bras	2/ policy year
Medical Supplies (aero chambers, air casts, braces, cryo cuffs, casts, crutches, cervical collars, clavicle straps, lymphedema sleeves, rib belts, sacroiliac corsets, shoulder immobilizers, splints, and trusses)	$500
Mobility Aids (canes, reaching aids, raised toilet seats, grab bars, bathub/toilet safety rails, and bathtub/transfer benches)	$500
Ostomy Supplies	$500
Oxygen Equipment (including sleep apnea supplies)	$500
Sleep Apnea Machine (CPAP, APAP or BIPAP)	$2,500 lifetime
Walkers	1/ 5 policy years up to $500
Wigs	1/ policy year

8. **Wheelchairs, Motorized Scooters & Hospital Beds** – provides payment for the purchase or rental of wheelchairs, geriatric chairs, motorized scooters, and/or *hospital* beds when *medically necessary*. A prescription, complete with *medical condition*, from a *physician* is required.

PremierPlan	ChoicePlan	EssentialPlan
80% to a combined lifetime maximum of $10,000	80% to a combined lifetime maximum of $10,000	80% to a combined lifetime maximum of $10,000

9. **Custom Made Foot Orthotics & Orthopedic Shoes –** provides payment for custom made foot orthotics and for the cost of one pair of custom-made shoes or the cost to modify one 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 orthotics to be covered, an accredited podiatric biomechanics laboratory must create the orthotic using a 'cast or scan' and raw materials.

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

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

   b. digital impression of the foot.

   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.

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

PremierPlan	ChoicePlan	EssentialPlan
$300 combined maximum per person, per *policy year*	$300 combined maximum per person, per *policy year*	$300 combined maximum per person, per *policy year*

10. **Private Duty Nursing** – provides payment for private duty nursing *services* in *hospital* and in-*home* care. *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 in-*home* care, 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 *hospital*ized.

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

PremierPlan	ChoicePlan	EssentialPlan
80% to $5,000 maximum per person, per *policy year*	80% to $3,000 maximum per person, per *policy year*	80% to $1,000 maximum per person, per *policy year*

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

    You must notify *GMS* and receive approval for *treatment* no later than six months from the date of injury. All *treatment* must be completed within twelve 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.

PremierPlan	ChoicePlan	EssentialPlan
$2,000 per person, per injury	$2,000 per person, per injury	$2,000 per person, per injury

12. **Artificial Limbs, Eyes & Larynx** – provides payment for the purchase of artificial limbs (including myoelectric limbs), eyes and/or larynx.

PremierPlan	ChoicePlan	EssentialPlan
$10,000 lifetime maximum per person	$10,000 lifetime maximum per person	$10,000 lifetime maximum per person

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

PremierPlan	ChoicePlan	EssentialPlan
$325 maximum for *single* mastectomy patients or $650 maximum for bilateral mastectomy patients; in the two most recent *policy years*	$325 maximum for *single* mastectomy patients or $650 maximum for bilateral mastectomy patients; in the two most recent *policy years*	$325 maximum for *single* mastectomy patients or $650 maximum for bilateral mastectomy patients; in the two most recent *policy years*

14. **GMS Care Network** – provides *you and your dependants* with *services* to support *your* health and wellbeing, including:

    Telemedicine – connect with a Canadian-licensed general practitioner by phone, video or text message to get help with minor medical needs, prescriptions, and more. Consultations are available for *you and your dependants*. Everything is confidential, and *you* own and manage *your* health record of these consultations.

    Mental health and wellbeing support – connect with counsellors by video, phone, or in-person for support with a variety of concerns such as:

    - self-esteem
    - anxiety
    - stress
    - depression
    - grief and loss
    - legal and financial matters
    - work and career
    - life transitions
    - individual and couples counselling

    Crisis support is available 24/7/365 by calling 1-866-798-6793.

    Choose *your* counsellor based on clinical fit, cultural background, language, therapy approach and more. Don't feel that *your* provider is a good fit? Unmatch yourself and choose a new provider. It's that simple.

    Digital Cognitive Behavioural Therapy – work at *your* own pace using this online cognitive behavioural therapy program. It provides learning modules and tools to help support mental health.

PremierPlan	ChoicePlan	EssentialPlan
Included	Included	Included

    You and your dependants can access help 24/7 by:

    - calling **1-866-798-6793**;
    - online at **app.gmscarenetwork.ca**; or
    - download the app for *your* mobile device

    *Policyholder*s can also access it through their My GMS account. Select Policies & Resources on the right-hand side of the screen to access the link to the GMS Care Network.

    To access the GMS Care Network online or through the app, *you* will first need to create an account by following the prompts.

    GMS Care Network Services provided by Greenshield+

A.2. Health Conditions

In addition to the General Conditions listed on page 14, the following conditions apply to the Health Benefits:

1. Health benefits are available within Canada unless otherwise stated.
2. Goods and *services* totaling $500 or more must have prior approval from *GMS* before the purchase of goods or *services* have begun. If a prior approval is not submitted prior to purchase of goods or commencement of *services*, benefits otherwise payable may be limited to $500.
3. *GMS* will pay *reasonable and customary* charges up to the maximum amounts set out in each benefit subject to exclusions and limitations.

A.3. Health Exclusions

In addition to the General Exclusions listed on page 17, the following exclusions apply to the Health Benefits:

1. Expenses for cosmetic purposes;
2. Expenses for diagnostic or investigative testing;
3. Expenses for *services* provided by a *family member*;
4. Expenses related to the cost of oxygen;
5. Expenses relating to non-prescription eyewear;
6. Expenses when no transport occurs or for *transportation* to or from *physicians*' offices, laboratories and medical clinics;
7. Expenses for wheelchairs, motorized scooters and *hospital* 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*;
8. Expenses for hearing aid batteries or replacement ear moulds.

B. PRESCRIPTION DRUG COVERAGE

B.1. Prescription Drug Benefits

Drugs prescribed in writing by a *physician* in Canada and listed on the *GMS Formulary* will be covered as stated in the Schedule of Benefits on page 2 of this booklet.

The *GMS Formulary* consists of two tiers: Tier 1 drugs are considered the most effective and affordable drugs on the market and will be covered up to 80%; Tier 2 drugs will be covered up to 50% subject to the exclusions set out in this section and the General Exclusions on page 17.

For each eligible *prescription drug*, *you* are responsible to pay the applicable coinsurance towards the cost of the *prescription drug* and dispensing fees.

B.2. Prescription Drug Conditions

In addition to the General Conditions listed on page 14, the following conditions apply to the *Prescription Drug* Benefit under this policy.

1. **Provincial Integration** – all claims for *prescription drugs* must be submitted to *your* provincial drug plan before being submitted to *GMS*. Coverage applies after the benefits through *government health plans*, including but not limited to the provincial drug plan, have been determined. When requested by *GMS*, *you* must apply for all publicly funded support programs that exist or may come to exist during the *policy year*.
2. **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.
3. **Compounding** – prescriptions for compounds must contain an active ingredient in a therapeutic concentration that is an eligible drug under the *prescription drug* benefits.
4. **Prior Authorization** – some *prescription drugs* require *you* to submit a Prior Authorization form for pre-approval by *GMS*. A complete list of these drugs and the Prior Authorization form can be found on www.gms.ca.

B.3. Prescription Drug Exclusions

In addition to the General Exclusions listed on page 17, the following exclusions and limitations apply:

1. Drugs available without a prescription;
2. Drugs intended for the *treatment* of sexual dysfunction;
3. Drugs for *treatment* of hair loss or to restore hair growth;
4. Experimental drugs;
5. Drugs used for the purpose of weight loss;
6. Drugs used for cosmetic purposes;
7. Cost of administering vaccinations;
8. Smoking cessation drugs;
9. Self-prescribed drugs or those drugs prescribed by a *family member*;
10. Vitamins;
11. Fertility drugs; and
12. Delivery and *transportation* costs associated with the acquisition of the drug(s).

C. DENTAL CARE COVERAGE

C.1. Dental Care Benefits

These benefits 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.*

Plan	Combined Maximum (per person, per *policy year*)	Percentage Paid
PremierPlan	$1,500	For all plans, *GMS* will pay 80% for Basic Dental *Services* and 50% for Major Dental *Services.*
ChoicePlan	$1,250	
EssentialPlan	$1,000	

Basic Dental Services

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

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

Major Dental Services

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

1. **Inlays, onlays, crowns, and veneers** – are provided when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where significant areas of previous fillings and decay prevent the use of more traditional filling materials to adequately restore the tooth; replacement when applied to a natural tooth must be separated by at least five *policy years*;

2. **Dentures**

   a. initial complete or partial dentures for teeth extracted while *you* are covered under this plan to a maximum of one per arch;

   b. replacement of complete or partial dentures when additional teeth are extracted while *you* are covered under this plan, or if the existing complete or partial denture is at least five years old; and

   c. denture adjustments, once per *policy year*;

3. **Bridge**

   a. initial bridge pontics and fixed bridge retainers on teeth extracted while *you* are covered under this plan; if there were three or more teeth missing prior to *you* becoming eligible for coverage under this policy, *GMS* will pay up to the cost of a partial denture only; and

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

4. **Implant Supported Appliances**

   a. crown and bridges supported by an implant are covered on teeth extracted while *you* are covered under this plan; if there were three or more teeth missing prior to becoming eligible for coverage 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 ten years old.

C.2. Dental Care Exclusions

In addition to the General Exclusions listed on page 17 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 *treatment*s.

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.3. Dental Care Conditions

In addition to the General Conditions listed on page 14, 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* are begun. 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*. For Alberta, where no fee guide exists, *GMS* will pay the maximum amounts as provided for in the CLHIA Reimbursement Guide. Any charges over and above the current *Dental Fee Guide* will be *your* responsibility.

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

4. **Prosthetic Devices** – provision of prosthetic devices including complete dentures, partial dentures, fixed bridgework (and crowns that are part of the bridgework) shall not be covered under this policy if the device was ordered or the *service* for the device was started before the *benefit effective date*.

5. **Necessary and Adequate** – the policy covers only necessary and adequate dental *services*. Where there is a dispute as to necessary and adequate dental *services*, the determination of *GMS* shall be final.

6. **Transitional Appliances** – *GMS* will pay for the *services* required for a permanent appliance deducting any amount paid for a temporary appliance when making the transition within one year of *services* commencing.

7. **Multiple Restorations** – multiple restorations submitted on the same tooth within 12 months will be limited according to *reasonable and customary* charges as indicated in the current *Dental Fee Guide*. Replacement of identical restorations will only be covered once every twelve 12 months.

D. ANNUAL TRAVEL COVERAGE

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 happens if my health changes?

- Changes in *your* health constitute a change in stability and may limit *your* available coverage.

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 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.

PLEASE READ YOUR POLICY CAREFULLY

	PremierPlan	ChoicePlan	EssentialPlan
Number of days per trip outside of Canada†	15 days	7 days	No coverage
Number of days per trip inside of Canada	183 days	183 days	
Maximum lifetime limit per person	$1,000,000	$1,000,000	

† Must be under 80 years of age on the effective date or renewal date of the plan for coverage outside of Canada. See D.3. Travel Conditions 1. for more details.

D.1. 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 up to the maximum provided by the plan option *you* have chosen. 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 one 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 three 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 includes 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 mental 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*.

D.2. Travel Exclusions

In addition to the General Exclusions listed on page 17 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 *trip*s 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 before *your departure date*, an official travel advisory is issued by the Canadian government, stating "Avoid nonessential travel" or "Avoid all travel" for the country, region, city or other destination (including cruise ships) that are part of *your* travel arrangements.

    To view the travel advisories, visit the Government of Canada Travel site: https://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.

D.3. Travel Conditions

In addition to the General Conditions listed on page 14, 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. **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.

4. **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.

5. **Interest Charges** – benefits payable shall not include interest charges.

6. **Purchase Requirement** – the travel benefit must have been purchased prior to *your* departure from *your province/territory of residence* to provide coverage.

7. **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.

8. **Right to Designate a Person** – *GMS* reserves the right to restrict or deny *your* right to designate persons to whom insurance money is payable.

9. **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*.

10. **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.

11. **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.

12. **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.

13. **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.4. Coverage Begins and Ends

Out-of-province/territory 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 *trip*s.

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*.

D.5. 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.

Trip Extensions

After departing *your province/territory of residence*, coverage for additional *trip* days may be purchased by contacting *GMS* prior to the expiry of the travel benefit under *your* Replacement Health Coverage. Availability of additional coverage with *GMS*' TravelStar travel coverage is subject to *you* meeting eligibility criteria and is not offered where *you* incurred medical *treatment* under the plan which it is topping up.

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 of the policy 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

Adding or removing an applicant from *your* plan may be done at any time prior to departure from *your province/territory of residence* for coverage to apply.

D.6. 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.

D.7. Making a Travel Claim

In the event of an annual travel claim, a claim form must be submitted to *GMS* by mail within 90 days of the illness or injury with the following supporting documentation:

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

HOW TO MAKE A CLAIM

The following conditions apply when applying for reimbursement of a medical *service*, supply or *treatment* under any of the Health, 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 13.

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 *GMS* Care Network.
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 detailed under this policy.

1. **Eligibility Requirements** – to be eligible to purchase, and continue to be eligible for coverage under this policy:
   a. the Replacement Health Coverage plan must be in effect no later than 90 days from when *your* group plan ends;
   b. *your* group plan must have been fully or partially employer-paid and provided by a Canadian insurer offering similar benefits;
   c. *you* must be 18 years of age and a resident of Canada;
   d. *you* must be covered under provincial health insurance; and
   e. any person(s) on the policy must be related to *you* in one of the following ways:
      i. Legally married to *you* or in a civil union;
      ii. Living with *you* in a conjugal relationship and presented as *your spouse* or partner; or
      iii. 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:
         1. under 21 years of age;
         2. under 25 years of age and attending a college or university full time; or
         3. physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on *you* while eligible under 1. or 2.

   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 six individuals consisting of: two parents with up to four eligible *dependants* or one parent and up to five eligible *dependants*. Additional *family member*s 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 dependent 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 ten 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 ten-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** – upgrading *your* plan is not permitted. *You* may downgrade *your* health plan option at time of renewal. Written notice must be sent to *GMS* requesting the change prior to expiry of the policy.

10. **Continuing Coverage for Over-age Dependants** – *dependants*, who no longer qualify as a *dependant* under the plan, may continue coverage under a *GMS* Replacement or Personal Health Plan by completing an application within 60 days of when coverage under the current policy would no longer apply. For Personal Health Coverage, the *dependant* will be entitled to the following:

    a. waiting periods will be waived;

    b. *prescription drug* benefits which are continued will not be subject to the pre-existing drug exclusion; and

    c. dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan in which they are transferring from.

11. **Continuing Coverage after Life Changes** – *dependants* may continue coverage under a *GMS* Replacement or Personal Health Plan when a new policy is necessitated as a result of divorce or separation by completing an application within 60 days of when coverage under the current *GMS* policy would no longer apply. For Personal Health Coverage, the *dependant* will be entitled to the following:

    a. waiting periods will be waived;

    b. *prescription drug* benefits which are continued will not be subject to the pre-existing drug exclusion; and

    c. dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan in which they are transferring from.

12. **Surviving Spouse & Dependant Coverage** – in the event of the *policyholder's* death, *GMS* will continue coverage for the surviving *spouse* and/or *dependant*. In order to continue coverage an application must be completed and submitted within 60 days of when coverage under the current *GMS* policy would no longer apply. Upon receiving the application, *GMS* will issue a new policy confirmation renaming the surviving *spouse* and/or *dependant* the *policyholder* and provide updated premium.

13. **Premiums** – are due on the date shown on the policy confirmation. The premium is determined according to the age of each insured person and the *province*/*territory* 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*/*territories*, premiums are adjusted according to the rates of the new *province*/*territory* and are effective on the date of the change.

14. **Currency** – all amounts stated in this policy are in Canadian funds.

15. **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

16. **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.

17. **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.

18. **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.

19. **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.

20. **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 coordinated with *your* other insurer(s) as follows.

    a. All benefits from any *government health plan* shall be determined and recovered first.

    b. *GMS* will pay eligible expenses only in excess of amounts covered by that of other insurer(s), including but not limited to, any employment related plan, extended health care plan, private or provincial vehicle insurance, credit card policy or any other insurance, whether collectible or not.

    c. If, however, the other source(s) of coverage is also "excess only", all benefits shall be determined and recovered from the policies based on the following priority:
        i. any plan not containing a co-ordination of benefits statement; then
        ii. any employment/retirement related plan; then
        iii. any other plan, including *GMS* (In this case, the benefits shall be prorated according to the maximum amounts that would have been payable as the result of the benefit contained under the respective plans. *You* agree that prorated sharing is what was intended when the policy was entered into and that sharing on any other basis including on the basis of independent or several liability and/or equal sharing is not what was intended or agreed to); then
        iv. the private plan (Replacement Health Coverage) where the insured person is covered as a member.

21. **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*.

22. **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.

23. **Authorization** – by purchasing this policy *you* are authorizing the following.

    a. *You* authorize any *physician*, health care provider, other person, *hospital* or institution to release to *GMS* and/or its authorized agents, representatives, affiliates or other *service* providers (collectively "*GMS*") any information covering *your* medical history, symptoms, *treatment*, exam, *diagnosis* and/or *services* rendered to *you* or any of *your dependants*.

    b. *You* authorize *GMS* to collect, store and use any information which is provided by *you* and any information obtained pursuant to clauses a. and c.

    c. *You* authorize *GMS* to obtain information from, or disclose information to any *government health plan*; the operator of any *hospital*, clinic, or other health facility; a *physician* or other health care provider; any insurance company; or any other *service* provider or third party as may be reasonably required. This information is intended for the purposes of administering the plan and communicating with *you*.

    d. Subject to legal or contractual restrictions, *you* may (upon reasonable written notice to *GMS*), choose to withdraw *your* consent to the collection, use and disclosure of such information. It is important to note that if *your* consent is withdrawn, *you* will restrict *GMS*' ability to administer *your* plan. Further, if *you* withdraw *your* consent, *GMS* may not be able to offer *you* products and *services* and *you* will limit *GMS*' ability to pay *your* claim(s).

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*/territory 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 and is allowed for each premium except the first. During the grace period, coverage remains in force and premiums continue to be payable by *you*. *GMS* 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. **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 ten business days prior to the scheduled date. If less than ten business days notice is given, and payment is withdrawn, *GMS* will refund the amount within 30 business days.

GENERAL EXCLUSIONS

The following general exclusions apply to all benefits detailed under this policy.

1. **Risky Activities** – *GMS* does not cover medical expenses resulting from *your* participation in:
   a. professional sports;
   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 participation in a horse race as a jockey.
2. **Criminal or Illegal Activity** – *GMS* does not cover any medical expenses resulting directly or indirectly from *your* criminal or illegal acts.
3. **Motor Vehicle Accident** – *GMS* does not cover any medical expenses resulting from a motor vehicle *accident*, unless not covered by any other policy.
4. **Medically Necessary** – *GMS* does not cover any medical expenses not *medically necessary* or which is considered by *GMS* to be experimental. *GMS*' opinion is final and binding.
5. **Unapproved Treatment** – *GMS* does not cover any 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. medical expenses for *services* or supplies which are experimental in nature, or that is not considered to be effective. *GMS*' opinion is final and binding.
6. **Result of Conflict** – *GMS* does not cover any medical expenses which results from *war*, *terrorism* or acts of foreign rebellion.
7. **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.
8. **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 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 five 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 money 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 plan types.

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

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

a. dosage adjustment for an anti-hypertensive or cholesterol lowering drug:

b. 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).

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 departures for a *trip*.

couple – consists of two 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 *dentist*ry. 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:

a. under 21 years of age; or

b. under 25 years of age, if the child is enrolled in at least three classes per semester or 60% of a full course load in a full-time student educational training facility;

c. 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.

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

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

effective date – *your* Replacement Health Coverage will be effective based on the later of the following:

a. the date in which *GMS* has accepted *your* application and *your* payment has been received by *GMS*;

b. the day following the end date of *your* group health plan this coverage is replacing; or

c. 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 two 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* listed under the *GMS formulary*. The *formulary* may vary and change over time.

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

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

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*.

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 *physician*s.

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

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

medical condition(s) – 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 – as referred to under travel coverage is a sudden, unexpected, unforeseeable and/or urgent happening that is acute and poses an immediate risk that requires immediate *medical consultation* and/or medical *treatment*. In the case of a *medical emergency* incurred during *your trip*, a *medical emergency* no longer exists when the medical evidence indicates that no further medical *treatment* is required at *your* destination, or indicates *you* are able to return to *your province/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/territory, state or country where the *services* are rendered to practice medicine and surgery without restriction, or a nurse practitioner registered by their provincial regulatory agency. Does not include a naturopath, herbalist, or *home*opath.

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 *your province/territory of residence* or 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 – one person.

spouse – a legal *spouse* by virtue of a religious or civil marriage or a person who has been residing with the *policyholder* continuously for at least one 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, 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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