

This policy outlines the terms and conditions of *your* Individual Health plan with Group Medical Services (GMS). Please refer to the appropriate sections for the health plan and for the additional options that *you* have purchased. Some words in this policy have very specific meanings, which are set out in the Definitions section. These words appear in *italics* throughout the policy document.

Individual Health Plan Options Summary of Benefits

Benefits	OmniPlan®	ExtendaPlan®	BasicPlan
Eye Exams	\$75/2 years	n/a	n/a
Eye Glasses & Contact Lenses	\$200/2 years	n/a	n/a
Health Practitioners	\$35/visit, maximum \$300 per specialty	\$35/visit, \$250 combined maximum	n/a
Hearing Aids	\$800/5 years	\$500/5 years	n/a
Health Supplies & Equipment	\$500	\$500	n/a
Diabetic Supplies & Equipment	\$300	\$300	n/a
Oxygen Equipment	\$500/year; \$2,500 lifetime maximum	\$500/year; \$1,500 lifetime maximum	n/a
Blood Pressure Monitors	1/policy/5 years	1/policy/5 years	n/a
Custom Made Foot Orthotics	80% - 1/3 years adults; 1/year <16 years	80% - 1/5 years adults; 1/year <16 years	n/a
Therapeutic Shoes	\$200	\$200	n/a
Mobility Aids	\$300/policy/year	\$300/policy/year	n/a
Ostomy Supplies	\$300	\$300	n/a
Funeral Expenses	\$4,000	n/a	n/a
Out-of-Province Referral	\$50,000/person lifetime maximum	\$50,000/person lifetime maximum	n/a
Ambulance	Unlimited	Unlimited	\$2,000
Air Ambulance	\$8,000	\$5,000	\$3,000
Casts and Crutches	Unlimited	Unlimited	Unlimited
Preferred Hospital Rooms	45 days to \$3,500	\$1,000	\$500
Private Duty Nursing	80% to \$2,500	80% to \$2,500	80% to \$1,500 (in-hospital only)
In-Hospital Drugs	\$2,000	\$1,000	\$1,000
Accidental Injury to Natural Teeth	\$5,000/injury	\$2,000/injury	\$500/injury
Wheelchairs, Motorized Scooters & Adjustable Beds	\$1,000/policy/5 years	\$750/policy/5 years	\$500/policy/5 years
Artificial Limbs, Eyes & Larynx	\$5,000	\$5,000	\$5,000
Patient Walkers	80% to \$300/policy/5 years	80% to \$300/policy/5 years	80% to \$300/policy/5 years
Breast Prosthesis	\$325 single; \$650 bi-lateral/2 years	\$325 single; \$650 bi-lateral/2 years	\$175 single; \$350 bi-lateral/2 years
Medical Second Opinion <i>(OmniPlan® - Enhanced only)</i>	Request a second opinion if you or a family member are diagnosed with a serious illness.	n/a	n/a

Additional Coverage	
Prescription Drug	Payment up to \$3,500 for <i>formulary</i> drugs.
Prescription Drug - Enhanced	Payment to an overall maximum of \$5,000 for prescription drugs and oral contraceptives. Includes \$500 for pre-existing medications.
Dental Care	Preventative Care, Basic and Major Services.
Hospital Cash	\$100 per day up to 30 consecutive days of hospitalization.
Annual Travel	Out-of-country and out-of-province coverage, \$2,000,000, 15, 30 or 48 days.

I. HEALTH

A. Health Benefits

Included below is the coverage available under OmniPlan®, ExtendaPlan® or BasicPlan, as applicable.

1. Eye Exams

Payment for eye examinations, including refractions. This benefit excludes eye examinations related to surgical procedures and any form of optical surgery.

OmniPlan®

Maximum \$75 per person in the two (2) most recent *policy years*, including the current *policy year*.

2. Eyeglasses and Contact Lenses

Payment for eyeglasses, contact lenses and/or corrective laser eye surgery. Eyeglasses and contact lenses require the written prescription of a *physician* or optometrist. This benefit excludes payment for sunglasses and eyeglasses for cosmetic purposes.

OmniPlan®

Maximum \$200 per person in the two (2) most recent *policy years*, including the current *policy year*.

3. Health Practitioners

Payment of the costs for the following forms of *treatment*: acupuncture, chiropractic *treatment*, chiropody/podiatry, clinical psychology, massage therapy, naturopathic *treatment*, speech therapy and physiotherapy. All *treatments* must be provided by health practitioners who are legally authorized by an appropriate governing association to practice their profession and who are not immediately related to *you*. *GMS* reserves the right to determine which health practitioner(s) will be eligible for reimbursement. *Treatments* by a massage therapist, physiotherapist or psychologist require the written referral of a *physician* each *policy year*. This benefit excludes diagnostic and investigative testing. *GMS* will only cover one type of *treatment* within the scope of practice for each individual practitioner.

OmniPlan®

Maximum \$35 per visit to a maximum of \$300 per specialty per person per *policy year*.

ExtendaPlan®

Maximum \$35 per visit to an overall maximum of \$250 (for all health practitioners) per person per *policy year*.

4. Hearing Aids

Payment for a hearing aid when fitted by an audiologist or when an audiogram is conducted by an audiologist. This benefit excludes payment for hearing tests, hearing aid fitting services, batteries and additional and/or replacement ear moulds. Reimbursement for this benefit is available following one (1) full year of enrolment in this plan.

OmniPlan®

Maximum \$800 per person in the five (5) most recent *policy years*, including the current *policy year*. Applies to purchase or repair.

ExtendaPlan®

Maximum \$500 per person in the five (5) most recent *policy years*, including the current *policy year*. Applies to purchase only.

5. Health Supplies and Equipment

Payment for i) the purchase or rental of splints, braces that contain metal or hard plastic components; ii) the purchase of wigs, trusses, rib belts, air casts, clavicle straps, cervical collars, shoulder immobilizers, sacroiliac corsets, embolic stockings (to a maximum of four (4) pair per person per *policy year*); and iii) aero chambers. A *physician* must prescribe each of the above items in writing.

OmniPlan®

Overall maximum of \$500 per person per *policy year*.

ExtendaPlan®

Overall maximum of \$500 per person per *policy year*.

6. Diabetic Supplies and Equipment

Payment for the purchase of diabetic supplies and equipment, including testing devices, when ordered in writing by a *physician* for use in the home. This benefit excludes insulin and other prescription medications.

OmniPlan®

Maximum \$300 per person per *policy year*.

ExtendaPlan®

Maximum \$300 per person per *policy year*.

7. Oxygen Equipment

Payment for the cost of oxygen equipment rental and/or CPAP supplies when ordered in writing by a *physician* for personal use in the home. This benefit excludes CPAP machines and the cost of oxygen.

OmniPlan®

Maximum \$500 per person per *policy year* to a lifetime maximum of \$2,500 per person.

ExtendaPlan®

Maximum \$500 per person per *policy year* to a lifetime maximum of \$1,500 per person.

8. Blood Pressure Monitors

Payment for the purchase of a blood pressure monitor when ordered in writing by a *physician* for personal use in the home.

OmniPlan®

Maximum one (1) per *policy*, in the five (5) most recent *policy years*, including the current *policy year*.

ExtendaPlan®

Maximum one (1) per *policy*, in the five (5) most recent *policy years*, including the current *policy year*.

9. Custom Made Foot Orthotics

Payment of 80% of the purchase of custom made foot orthotics. The orthotic must be made by an accredited podiatric biomechanics laboratory and created using a three-dimensional impressing technique or a three-dimensional model of the foot and be made from raw materials. Three-dimensional impressing techniques include foam box impressing, plaster casting and direct mould. This benefit excludes payment for the costs of assessment, casting or scanning.

OmniPlan®

Maximum one pair per person in the three (3) most recent *policy years*, including the current *policy year* for adults, and one pair per person per *policy year* for children under sixteen (16) years of age.

ExtendaPlan®

Maximum one pair per person in the five (5) most recent *policy years*, including the current *policy year* for adults, and one pair per person per *policy year* for children under sixteen (16) years of age.

10. Therapeutic Shoes

Payment for the purchase, repair, or replacement of customized therapeutic shoes. A written prescription, including a medical diagnosis, is required from an orthopaedic *surgeon*, podiatrist, pedorthist, orthotist, chiropodist, or an attending *physician*. The shoe must be custom built, specifically designed or melded, or permanently modified for the covered person, and supplied by a certified pedorthist, orthotist, or chiropodist/podiatrist. The receipt must be completely itemized, with the type of shoe including all modifications done. This benefit excludes payment for sandals, runners or boots, or any shoes that have pointed toes.

OmniPlan®

Maximum \$200 per person per *policy year*.

ExtendaPlan®

Maximum \$200 per person per *policy year*.

11. Mobility Aids

Payment for the following mobility aids, when accompanied by a *physician's* letter confirming necessity: canes, reaching aids, raised toilet seats, grab bars, bathtub/toilet safety rails, and bathtub/transfer benches when intended for personal use in the home. *GMS* will also provide payment for canes and reaching aids when used in personal care homes and nursing homes.

Omniplan®	ExtendaPlan®
Maximum \$300 per policy per <i>policy year</i> .	Maximum \$300 per policy per <i>policy year</i> .

12. Ostomy Supplies

Payment for ostomy supplies when required for use in the home.

Omniplan®	ExtendaPlan®
Maximum \$300 per person per <i>policy year</i> .	Maximum \$300 per person per <i>policy year</i> .

13. Funeral Expenses

Payment for funeral expenses provided the death is *accidental* and not the result of sickness or disease either as a cause or effect. *GMS* requires a death certificate, a satisfactory statement of death such as a *physician's* letter, and receipts for funeral expenses.

Omniplan®
Maximum \$4,000 per person.

14. Out-of-Province Referral

Payment for *physician*, anaesthetic, radiology, laboratory, *hospital*, and ambulance services outside *your province of residence*, for *treatment* which is not available in *your province of residence*, when recommended in writing by a specialist *physician*. The claim must have prior written approval from *GMS*. *GMS* will not approve payment for *treatment* where there are provincially funded *treatment* options available in *your province of residence*. Payment will not be made for *treatment* related to any condition, disease or illness that existed in the twelve (12) months prior to the *policy effective date*. Referrals for *treatment* outside Canada are excluded from this benefit.

Omniplan®	ExtendaPlan®
Maximum \$50,000 per person per lifetime.	Maximum \$50,000 per person per lifetime.

15. Ambulance

Payment for *emergency* transport by licensed professional road ambulance to the nearest *hospital* or health centre equipped to provide the necessary *emergency* in-patient and out-patient *treatment*. As well, 50% of the costs of road ambulance transport returning you to your place of permanent residence if you are bedridden at the time of your discharge. This benefit excludes payment for transportation to *physicians'* offices and medical clinics.

Omniplan®	ExtendaPlan®	BasicPlan
Maximum Unlimited	Maximum Unlimited	Maximum \$2,000 per person per <i>policy year</i> .

16. Air Ambulance

Within *your province of residence*, 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 out-patient *treatment*, when authorized by a *physician* and with prior *GMS* approval.

Omniplan®	ExtendaPlan®	BasicPlan
Maximum \$8,000 per person per <i>policy year</i> .	Maximum \$5,000 per person per <i>policy year</i> .	Maximum \$3,000 per person per <i>policy year</i> .

17. Casts and Crutches

Payment of the costs for fibreglass casts and for the purchase or rental of crutches.

Omniplan®	ExtendaPlan®	BasicPlan
Maximum Unlimited	Maximum Unlimited	Maximum Unlimited

18. Preferred Hospital Room

Reimbursement of private or semi-private *hospital* room costs. The *benefit effective date* must precede the *hospital* admittance date. This benefit excludes stays for convalescent and respite care.

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

19. Private Duty Nursing

Payment of 80% of private duty nursing cost, when ordered in writing by a *physician*. All 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*. Nursing services rendered in licensed institutional-type facilities are excluded from this benefit. The *benefit effective date* must precede the *hospital* admittance date.

Omniplan®	ExtendaPlan®	BasicPlan
Maximum \$2,500, in- <i>hospital</i> or in-home as palliative care per person per <i>policy year</i> . Nursing services in the home must commence immediately following your release from the <i>hospital</i> and be consistent with the <i>treatment</i> of the condition for which you were hospitalized.	Maximum \$2,500, in- <i>hospital</i> or in-home as palliative care per person per <i>policy year</i> . Nursing services in the home must commence immediately following your release from the <i>hospital</i> and be consistent with the <i>treatment</i> of the condition for which you were hospitalized.	Maximum \$1,500, in- <i>hospital</i> , per person per <i>policy year</i> .

20. In-Hospital Drugs

Payment for the cost of prescription drugs, which are not covered by *your* provincial prescription drug service plan, when supplied and administered by a *hospital* to in-patients. This benefit excludes fertility drugs, drugs for the *treatment* of sexual dysfunction, lifestyle drugs, experimental drugs, diet drugs, drugs used for cosmetic purposes, drugs normally available over the counter, and drugs used for the cessation of smoking.

Omniplan®	ExtendaPlan®	BasicPlan
Maximum \$2,000 per person per <i>policy year</i> .	Maximum \$1,000 per person per <i>policy year</i> .	Maximum \$1,000 per person per <i>policy year</i> .

21. Accidental Injury to Natural Teeth

Payment for the services of a *dentist* necessitated by *accidental* injury, such as a direct blow to the mouth, but not by an object placed in the mouth. The injury must have occurred during the *policy year*. The injury must be reported to *GMS* within six (6) months of the *accident* occurring and coverage must be in place and continuous from the date of injury to the date that dental services are provided in order for this benefit to be payable. Payment for any claim is based on the date services are rendered and not on the date of injury. Reimbursement will be in accordance with the *dental fee guide for your province of residence* in effect at the time that the services are rendered. Services totaling \$500 or more must have prior approval from *GMS*. This benefit excludes dental implants. All services must be completed within twelve (12) months of the date of injury.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$5,000 per injury.	Maximum \$2,000 per injury.	Maximum \$500 per injury.

22. Wheelchairs, Motorized Scooters and Adjustable Beds

Payment for the purchase or rental of wheelchairs (including geriatric chairs with a 24" or greater wheel size), motorized scooters, and/or adjustable beds when ordered in writing by a *physician*. This benefit is only available following one (1) full year of enrolment in the plan. The benefit excludes adjustable beds for individuals that are confined to, or resident in, an active *treatment hospital*, a convalescent facility, a nursing home, an extended care facility, a rehabilitation centre, a rest home or a personal care home. Payment for purchase will only be made directly to the provider.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$1,000 per policy in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .	Maximum \$750 per policy in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .	Maximum \$500 per policy in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .

23. Artificial Limbs, Eyes and Larynx

Payment for the purchase of artificial limbs, eyes and/or larynx. This benefit excludes myoelectric limbs.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$5,000 per person per <i>policy year</i> .	Maximum \$5,000 per person per <i>policy year</i> .	Maximum \$5,000 per person per <i>policy year</i> .

24. Patient Walkers

Payment of 80% of the costs for the purchase or rental of patient walkers when ordered in writing by a *physician*.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$300 per policy in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .	Maximum \$300 per policy in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .	Maximum \$300 per policy in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .

25. Breast Prosthesis

Payment for the purchase of an artificial breast prosthesis. A written *physician's* referral is required for bilateral mastectomy patients. This benefit excludes surgical brassieres.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$325 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> , for single mastectomy patients, or maximum \$650 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> for bilateral mastectomy patients.	Maximum \$325 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> , for single mastectomy patients, or maximum \$650 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> for bilateral mastectomy patients.	Maximum \$175 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> for single mastectomy patients, or maximum \$350 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> , for bilateral mastectomy patients.

B. Health Benefit Terms and Conditions

1. Reimbursement for goods and services purchased will be based on *reasonable and customary* charges within your *province of residence*.
2. Goods may be purchased anywhere within Canada.
3. For BasicPlan and ExtendaPlan® services must be provided within your *province of residence*. For OmniPlan® services may be provided anywhere within Canada.

II. MEDICAL SECOND OPINION

A. Medical Second Opinion Benefits

Included below is a listing of the eligible Medical Second Opinion benefit included in OminPlan® - Enhanced.

1. If you are diagnosed with, or suspected of having, a qualifying medical condition, *GMS* will provide a Medical Second Opinion obtained from an independent medical centre with expertise pertaining to your medical condition.

B. Medical Second Opinion Terms And Conditions

The following terms and conditions apply:

1. All persons covered under your plan including up to four (4) parents or parents-in-law of the *policyholder* are entitled to receive one Medical Second Opinion per covered condition, per *policy year*.
2. A list of qualifying medical conditions and qualified providers of the second opinion service are available from *GMS* and may be amended by *GMS* from time to time.
3. This service is provided in conjunction with and requires full cooperation of your *physician*; including providing all medical records upon request.
4. Upon making a request for a Medical Second Opinion, you will be required to complete application and release forms, which will be provided by *GMS*.

ADDITIONAL COVERAGE OPTIONS

The following is a listing of eligible benefits for Annual Travel, Dental Care, Prescription Drug, Prescription Drug-Enhanced, and Hospital Cash *additional coverage options*.

III. ANNUAL TRAVEL BENEFIT

IMPORTANT NOTICE

- 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 and limitations.
- A pre-existing medical exclusion applies to medical conditions and/or symptoms that existed prior to your departure. Check the policy to see how this applies to you.
- In the event of an *accident*, injury or sickness, your prior medical history may be reviewed when a claim is reported. Please refer to the section on travel exclusions and limitations.
- 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.

PLEASE READ YOUR POLICY CAREFULLY AT THE TIME OF PURCHASE

A. Travel Benefits

Travel benefits include:

1. **Hospitalization** – *Hospital* accommodations up to semi-private rooms and *hospital* services and supplies necessary for the *emergency* care during hospitalization. One follow-up visit (excluding on-going *treatment*) is covered in situations where the medical process in dealing with the *emergency* requires such a follow-up visit. The follow-up visit must take place within fourteen (14) days of the initial *emergency*.
2. **Medical Services** – *Treatment* by a *physician* or *surgeon*.

3. **Diagnostic Services** – X-rays and other diagnostic tests. Magnetic resonance imaging, computerized axial tomography scans, sonograms, ultrasounds and biopsies are excluded unless pre-authorized by GMS.
 4. **Out-Patient Treatment** – Out-patient emergency room expenses.
 5. **Prescription Drugs** – Drugs and medication obtained on the prescription of the attending physician and supplied by a licensed pharmacist, to a maximum of a thirty (30) day prescription. Drugs or medications that are lost, stolen or damaged during a trip during your coverage period are covered up to a maximum of \$50 per person. Any associated physician's expenses related to lost, stolen, or damaged drugs or medications are excluded from coverage.
 6. **Private Duty Nursing** – Expenses to a maximum of \$5,000 per person for the professional services of a registered nurse (non-family member) for private duty nursing while hospitalized during an acute emergency illness or injury.
 7. **Ambulance** – Expenses for the use of a licensed road ambulance in an emergency situation that requires immediate transportation to the nearest hospital where adequate facilities are available.
 8. **Air Ambulance** – Expenses for the use of an air ambulance or regularly scheduled airline to transport you back to your province of residence for further in-hospital treatment, upon the written recommendation of the attending physician and with prior GMS approval. This benefit excludes helicopter transports.
 9. **Remote Evacuation** – Expenses to a maximum of \$5,000 per person for your evacuation from a mountainous region, remote location or sea to the nearest, most accessible hospital.
 10. **Special Attendant** – One return trip economy airfare for a medical attendant, if medically necessary and pre-approved by GMS, to accompany you back to your province of residence. The attendant must not be a friend, relative, associate or other person who was travelling with you when the emergency occurred.
 11. **Return of Family Member** – A one-way economy class airfare by the most direct route to the departure point, to a maximum of \$1,000, for the return of one (1) covered, accompanying family member if GMS requires that you return to Canada or your province of residence for immediate medical treatment or in the event of your death. This benefit must be pre-approved by GMS.
 12. **Paramedical Services** – Expenses, up to an aggregate maximum of \$300 per person, for the emergency services of an osteopath, physiotherapist, chiropractor, chiropract, and/or podiatrist.
 13. **Accidental Dental** – Expenses for the repair or replacement of natural teeth or permanently attached artificial teeth necessitated by an accidental blow to the mouth, to a maximum of \$2,000 per person. Expenses for treatment of the relief of dental pain, to a maximum of \$250 for such treatment. This benefit excludes dental implants.
 14. **Return of Remains** – When death results from a covered emergency, the expenses for either the preparation and transportation of the deceased to his/her province of residence, to a maximum of \$3,000 per person, or the expense of cremation or burial at the place of death, to a maximum of \$2,000 per person.
 15. **Family to Bedside** – A round-trip, economy class airfare by the most direct route, up to a maximum of \$3,000, in the event you become hospitalized for at least three consecutive nights as a result of a covered emergency, and the attending physician advises the necessary attendance of one of your family members or a close friend. In addition, reimbursement of up to \$150 per day to a maximum of \$750 for reasonable and customary expenses incurred by the transported person once they arrive. Original paid receipts for the expenses incurred are required. This benefit must be pre-approved by GMS.
 16. **Family Transportation** – When death results from a covered emergency, a single round-trip, economy class airfare for an immediate family member plus up to \$300 for meals and accommodation, to an aggregate maximum of \$2,000 to identify the deceased.
 17. **Return of Vehicle** – Expenses to a maximum of \$2,000 with prior GMS approval, for returning your vehicle to your residence or the nearest appropriate vehicle rental agency, when you and any travel companions are unable to do so due to unexpected illness or accidental injury. This benefit is only available when GMS returns you to your province of residence for further in-hospital medical treatment. Eligible expenses include the return of a vehicle performed by a professional agency or the following necessary and reasonable expenses incurred by an individual returning the vehicle on your behalf: fuel, meals, overnight accommodation, and one-way economy airfare. Expenses incurred by anyone travelling with the person returning the vehicle are not covered. Written medical certification and original paid receipts for the expenses incurred are required.
 18. **Return of Cat or Dog** – Reimbursement to a maximum of \$300 to return your cat or dog to your province of residence, when GMS returns you to your province of residence for further in-hospital medical treatment.
 19. **Child Care** – Reimbursement to a maximum of \$500, with prior GMS approval, for licensed care of dependant children if they are travelling with you, should you be hospitalized due to a medical emergency.
 20. **Escort of Insured Dependant** - Reimbursement of one-way, economy class airfare by the most direct route to return an accompanying child/children (up to the age of eighteen (18) years), and an escort when necessary, to the departure point. This benefit must be pre-approved by GMS.
 21. **Coverage Continuation** – If coverage expires while you are hospitalized due to an emergency, applicable coverage will continue for you, your spouse and any dependants travelling with you for up to seventy-two (72) hours after you are discharged from the hospital.
 22. **Out-of-Pocket Expenses** – Reimbursement for reasonable and customary expenses, up to \$150 per day to a maximum of \$1,000, for accommodations, meals, necessary telephone calls and taxi or bus fares incurred by an accompanying family member in the event you are hospitalized as at your scheduled return date. Original paid receipts for the expenses incurred are required. This benefit must be pre-approved by GMS.
 23. **24-Hour Travel Assistance Services:**
 - a) co-ordination of all medical care, transportation, and repatriation;
 - b) telephone interpretation services in most languages; and
 - c) monitor progress during treatment and recovery by managed care.
- B. Travel Terms and Conditions**
1. GMS will pay the reasonable and customary charges up to the maximum amount payable of \$2,000,000 (and subject to the maximum coverages described in Part III A. above) of eligible expenses in the event that an unexpected medical emergency occurs outside of your province of residence or Canada.
 2. Individuals age eighty (80) years and older as of your renewal date are eligible only for benefits for travel within Canada. There is no coverage for travel outside of Canada within this policy for individuals age eighty (80) years or older.
 3. For expenses to be eligible for reimbursement under this policy, the emergency treatment for a sudden or unexpected illness or accidental injury and the necessary diagnosis and treatment must occur within the first one hundred and eighty three (183) days after leaving your province of residence if travelling within Canada; within the first fifteen (15), thirty (30), or forty-eight (48) days after leaving Canada. The number of days per trip depends on the additional coverage option you have chosen.
 4. You must purchase the travel additional coverage option prior to your departure date from your province of residence.
 5. Should any changes in your health occur after the application date and prior to the policy effective date, GMS must be contacted and the information in your application updated.
 6. Changes to Annual Travel Coverage:
 - a) Prior to departure from your province of residence: changes to coverage to increase the number of days may be made at any time during the policy year subject to payment of the additional premiums.
 - b) After departure from your province of residence: changes to coverage to increase the number of days may be made, subject to the following conditions;
 - i) the request to increase your coverage is provided to GMS two working days prior to the expiration date of your existing travel coverage;
 - ii) you have not required out-of-province or Canada emergency medical services in excess of \$500 during the current policy year;
 - iii) you have not made travel claims during the current policy year;
 - iv) you are not anticipating any medical treatment; and
 - v) you have paid the appropriate premiums.
 7. When taking multiple trips outside of Canada, you must return to Canada for a minimum of seventy-two (72) hours prior to making a subsequent trip in order to be eligible for the maximum trip length of your policy. This condition does not apply in cases where trip duration is less than fourteen (14) days. However, all conditions and exclusions are applicable to each subsequent trip.
 8. Payment will only be made in excess of any deductibles and any amounts covered by your provincial government plan or other insurance plan(s).
 9. GMS, in consultation with your attending physician, reserves the right to transfer you to another hospital or medical facility capable of providing the necessary medical services, or to return you to your province of residence. If you refuse to do so GMS will have no further liability under this policy.
 10. You agree that GMS is authorized to receive reports indicating diagnosis and services or treatment rendered or provided to you from any physician, health care provider, other person, hospital or institution.
 11. It is your responsibility to provide proof that the dates of travel are consistent with the terms of this policy.
 12. **Waiting Periods:**
Travel coverage has no waiting period.

13. Claims:

- a) You or someone on your behalf must contact GMS prior to treatment whenever possible. Failure to contact GMS within twenty-four (24) hours of receiving medical treatment or admission to hospital will limit benefits otherwise payable to 70% of eligible charges to an aggregate maximum of \$50,000.
- b) If you incur eligible travel expenses, you will also need to provide GMS the original copy of the itemized account of expenses, proof of departure date, the name of any other travel insurance provider (and a copy of each policy) and particulars of all provincial health plan payments.

14. Where trip lengths exceed the maximum number of days provided by your policy and the above requirements are met, you may apply for additional daily travel coverage through the GMS TravelStar® product. You must meet all eligibility requirements as defined in the GMS TravelStar® policy and must pay the appropriate additional premiums based on the total length of your trip.

C. Travel Exclusions and Limitations

The following exclusions and limitations apply to the Travel Benefits:

- 1. Coverage for any medical conditions and/or symptoms that existed prior to the departure date from your province of residence are subject to the following:
 - a) No benefits will be paid for any claims in the following circumstances:
 - i) If your medical condition(s) or related condition(s) and/or symptom(s) (whether or not a diagnosis has been determined) have not been stable at any time in the exclusion period specified in 1.b) below; or
 - ii) if at any time during the exclusion period specified in 1.b) below:
 - any heart condition has not been stable; or
 - any lung condition has not been stable.
 - b) Exclusion Period

Applies to:	Exclusion Period
All individuals, regardless of age, who: <ul style="list-style-type: none"> i) use home oxygen for heart and/or lung disease; ii) have undiagnosed episodes of syncope/fainting or falling; iii) have kidney failure; iv) have both heart disease and insulin dependent diabetes and are taking medication for both; or v) have congestive heart failure. The exclusion period applies to all of your medical conditions including but not limited to the five conditions noted above.	365 days immediately prior to your departure date from your province of residence
All other individuals, age 69 and under	90 days immediately prior to your departure date from your province of residence
All other individuals, age 70 and older	180 days immediately prior to your departure date from your province of residence

- 2. The following expenses are not covered by the policy:
 - a) Expenses incurred where you act against medical advice or the advice of GMS.
 - b) Expenses resulting from the regular care of a chronic condition.
 - c) Expenses incurred as a result of non-adherence with medical treatment prior to departure.
 - d) Expenses incurred when you travel to a country after such time that a travel advisory has been issued by the Canadian government recommending that Canadians do not travel to such country, or to specific regions within such country.
 - e) Any treatment, hospitalization or surgery (including elective, non-elective, personal comfort, dental or cosmetic) which is not considered to be an emergency, even if it is recommended by a physician.
 - f) Treatment at a diagnostic facility unless pre-approved by GMS.
 - g) Emergency air transportation or return to province of residence, which is not arranged and pre-approved by GMS.
 - h) Expenses related to any advice, investigation, treatment, hospitalization or surgery, which is a continuation of, subsequent to or a recurrence of an emergency medical treatment of a sickness or injury.

- i) Expenses for drugs and medication which are commonly available without a prescription, not legally registered or approved in Canada, experimental drugs or preventative medicines or vaccines.
- j) Expenses related to transplants at your destination, including but not limited to organ transplants, bone marrow or stem cell transplants.
- k) Any expenses incurred when travel is undertaken for the purpose of obtaining medical or surgical diagnosis or treatment, or when any medical treatment is pre-scheduled prior to departure from your province of residence.
- l) Expenses resulting when travel is booked or commenced contrary to medical advice.
- m) Pregnancy, miscarriage, childbirth or complications of any of these conditions occurring after the first eighteen (18) weeks of pregnancy.
- n) Routine or general physical examinations, check-ups or services of a continued nature following emergency treatment of a sickness or injury.
- o) Coronary artery angioplasty, cardiac surgery or implantable cardioverter defibrillator (ICD) (including any associated diagnostic tests or charges), unless necessary in a medical emergency and pre-approved by GMS.
- p) Any endovascular surgical procedures, either done individually or in combination with conventional surgical procedures.
- q) Any treatment which is considered by GMS to be experimental. GMS's opinion on the issue is final and binding.
- r) Treatment or services that contravene or are prohibited by the provincial laws of your province of residence and the federal laws of Canada that apply in your province of residence.
- s) Expenses for any persons holding a work visa from the country to which they are travelling; or for persons working in hazardous occupations.

IV. DENTAL CARE

A. Dental Care Benefits

If you have purchased the dental care option, the following dental care benefits are available within Canada based on the Dental Fee Guide within your province of residence as follows:

- 1. 1st policy year - 75% of the charges for eligible Basic Dental Services, to a maximum of \$500 per person per policy year (waiting period applies).
 2nd policy year - 80% of the charges for eligible Basic Dental Services and 50% of the charges for eligible Major Dental Services, to a combined maximum of \$750 per person per policy year.
 3rd policy year - 80% of the charges for eligible Basic Dental Services and 50% of the charges for eligible Major Dental Services, to a combined maximum of \$1,000 per person per policy year.
- 2. BASIC DENTAL SERVICES
 Subject to the limitations and exclusions stated within this policy, "Basic Dental Services" covers the following:
 - a) Complete dental examinations once per three (3) policy years, including the current policy year.
 - b) Limited oral examination procedures, recall and specific examinations will be subject to a combined maximum of two (2) examinations per policy year. Emergency examinations are unlimited.
 - c) Dental x-rays: one of either a complete series or panoramic x-ray per three (3) policy years, including the current policy year. Intra-oral and extra-oral x-rays to a maximum of ten (10) films per two (2) policy years, including the current policy year.
 - d) Treatment planning and consultation.
 - e) Diagnostic casts once per three (3) policy years, including the current policy year.
 - f) Scaling, to a maximum combined with periodontal root planing of ten (10) time units per policy year.
 - g) Periodontal root planing, to a maximum combined with scaling of ten (10) time units per policy year.
 - h) Polishing, two (2) time units per policy year.
 - i) Topical fluoride treatment, two (2) time units per policy year.
 - j) Pit and fissure sealants, once per tooth per lifetime for dependant children under eighteen (18) years of age.
 - k) Protective mouth guards, one (1) per policy year for dependant children under sixteen (16) years of age, and one (1) per three (3) policy years, including the current policy year, for adults.
 - l) Space maintainers and maintenance when a dentist has removed a primary tooth and an appliance is used to maintain space for a permanent tooth.
 - m) Interproximal diskings of teeth.

- n) Occlusal adjustment and equilibration, to a maximum of four (4) time units per *policy year*.
 - o) Basic restorations of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations, and plastic restorations.
 - p) Endodontic *treatment* for permanent teeth including *treatment* of the pulp chamber, root canal therapy, periapical services, miscellaneous surgical services (root amputation, hemisection, replantation, and perforations), and miscellaneous endodontic procedures (open and drain and non vital bleaching). Root canal therapy is limited to one (1) per tooth per five (5) *policy years*, including the current *policy year*.
 - q) Non-surgical periodontal services including management of oral disease and desensitization.
 - r) Surgical periodontal services including gingival curettage, gingivoplasty, gingivectomy, and flap approach. Each type of surgery is limited to one (1) per site (sextant) per *policy year*.
 - s) Removable prosthodontic services including denture repairs and additions, tissue conditioning for dentures and miscellaneous denture services (resilient liner and resetting of teeth).
 - t) Denture relining and rebasing, once per three (3) *policy years*, including the current *policy year*, per arch.
 - u) Denture remakes, when a replacement partial denture would be eligible for coverage.
 - v) Fixed prosthodontic repairs including replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, recementation, and fixed bridge/prosthesis repairs.
 - w) Basic oral surgery including erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions, and post surgical care.
 - x) Anesthesia.
 - y) Dental appliances for the control of oral habits (including Bruxism), one (1) per *policy year* for *dependant* children under sixteen (16) years of age and one (1) per three (3) *policy years* for adults.
3. MAJOR DENTAL SERVICES

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

- a) Inlays, onlays, crowns, and veneers 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. Replacements must be separated by at least five (5) *policy years*.
- b) Initial complete or partial dentures for teeth extracted while you are covered under this plan, to a maximum of one (1) per arch.
- c) Replacement of complete or partial dentures for teeth extracted while you are covered under this plan, or provided the existing complete or partial denture is at least five (5) years old. The cost of transitional dental work will be deducted from the final bridge or denture, if done within one (1) year.
- d) Denture adjustments, once per *policy year*.
- e) Initial bridge pontics and fixed bridge retainers on teeth extracted while you are covered under this plan.
- f) Replacement bridge pontics and fixed bridge retainers on teeth extracted while you are covered under this plan, or if the existing bridge pontic or fixed bridge retainer is at least five (5) years old.

B. Dental Care Exclusions and Limitations

The following exclusions and limitations apply to the Dental Care Benefits.

1. Services totaling \$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. GMS will pay for services and procedures only to the maximum amounts as provided for in the *Dental Fee Guide*. Any charges over and above the *Dental Fee Guide* will be your responsibility.
3. GMS will only cover standard cast chrome with external clasp retainers or acrylic partial denture. When an alternate appliance is supplied, GMS will pay the standard rates.
4. If you and the *dentist* decide on a personalized restoration in the construction of a denture, or specialized techniques are employed as opposed to standard procedures, GMS will provide benefits at the appropriate amount for a standard denture and standard techniques.
5. GMS will pay only for x-rays performed by a *dentist*.
6. The 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*.

7. If there were three or more teeth missing prior to you becoming eligible for coverage under this policy, then GMS will pay for a partial denture only.
8. Replacement of identical restorations will only be covered once every twelve (12) months.
9. Waiting Periods:
 - a) The *benefit effective date* for Dental Care Benefits coverage occurs after being enrolled in this option for three (3) months.
 - b) In situations where a person is changing from another GMS plan, waiting periods will be waived for any Dental Care benefits which were covered under the previous GMS plan, if the person was enrolled in that plan for at least three (3) months. The waiting period will not be waived if the previous GMS plan provided coverage only for *accidental injury* to natural teeth.
 - c) In situations where a person is transferring from another insurance carrier, waiting periods will be waived for comparable dental care benefits which were covered under the previous carrier's plan, if the person was enrolled in that plan for at least three (3) months. Proof of previous coverage is required in order to have benefit waiting periods waived.
10. The following services or supplies are excluded from coverage;
 - a) expenses compensable under Worker's Compensation Laws or any Government Agency;
 - b) expenses for cosmetic purposes only;
 - c) expenses for implants or crowns involved in an implant procedure and surgical insertion; and
 - d) replacement of lost or stolen dentures

IV. PRESCRIPTION DRUGS

A. Prescription Drug Benefits

If you have purchased the Prescription Drug option, GMS will provide payment for the following benefits within your *province of residence*:

1. Payment, to a maximum of \$3,500 per person per *policy year*, of the charges for drugs listed in your provincial health prescription drug services *formulary* plan when purchased in your *province of residence* and when ordered in writing by a *physician*. For those provinces which do not have a prescription drug services *formulary* plan claims will be adjudicated based on the Saskatchewan Prescription Drug Services *Formulary*.
2. If you have purchased the Prescription Drug – Enhanced option, GMS will provide payment for the following benefits within your *province of residence*:
Payment to an overall maximum of \$5,000 per person per *policy year*, subject to the following conditions:
 - a) Payment for newly prescribed drugs listed in your provincial *formulary* when purchased in your *province of residence*. For those provinces that do not have a provincial *formulary*, claims will be adjudicated based on the province of Saskatchewan *formulary*. This benefit excludes prescription medication for any pre-existing medical condition(s) at the time of application except as outlined in paragraph 2.c) below.
 - b) Payment for oral contraceptives listed in your provincial *formulary* when purchased in your *province of residence*.
 - c) Payment up to \$500 per person per *policy year* for:
 - i) Prescription medication for any pre-existing medical condition at the time of application.
 - ii) *Special status* drugs and all medications that legally require a prescription by law.
3. For each eligible prescription which is purchased, you are responsible for a \$4 charge per prescription, whether submitted using your GMS Prescription Drug Card or by manual submission to GMS.

B. Prescription Drug Exclusions and Limitations

The following exclusions and limitations apply to the Prescription Drug benefits:

1. This benefit excludes the following prescription drugs: drugs not listed in your provincial health prescription drug services *formulary* or drugs for which you have been granted *special status*, except where covered under the Prescription Drug – Enhanced option; fertility drugs; drugs intended for the *treatment* of sexual dysfunction; lifestyle drugs; drugs intended for the *treatment* of hair loss or to restore hair growth; experimental drugs; diet drugs; drugs used for cosmetic purposes; over-the-counter drugs; drugs used to stop smoking; vitamin products; blood and blood plasma; contraceptives, except where covered under the Prescription Drug – Enhanced option; contraceptive devices; foams or gels; atomizers; vaporizers; first aid supplies; food and nutritional systems; delivery and transportation charges; and video instructional kits, informational manuals or pamphlets.
2. This benefit excludes any prescription medication for any pre-existing medical condition(s) in which prescription medication has been taken in the six (6) months prior to application for coverage and/or prescription medication for which refills were authorized at the time of application, except where covered under the Prescription Drug – Enhanced option.

3. Generic substitutions may be used to replace brand name prescription drugs, unless "no substitutions" is specifically indicated on the prescription by the *physician*.
4. Prescriptions for compounds (a mixture of ingredients prepared by a pharmacist) are subject to the following restrictions:
 - a) Eligible ingredients include Benzoin Tincture; Hydrocortisone Powder; Liquor Carbonis Detergens (LCD); Menthol; Salicylic Acid; Sulfur; Tar Distillate; Erythromycin Powder; Clindamycin Powder; and Ketoconazole Powder.
 - b) Eligible bases include Aquaphor Ointment; Dermabase; Glaxal Base; Lanolin (Anhydrous); Petrolatum; and Schering Base.
 - c) One or more of the eligible ingredients may be added to any of the listed eligible bases or any topical medication that is an eligible benefit under the Prescription Drug Benefits.
 - d) Compounds must contain an active ingredient in a therapeutic concentration that is an eligible drug under the Prescription Drug Benefits.
 - e) The following compounds are ineligible: compounds created where two eligible bases are combined; compounds for cosmetic purposes, such as baldness, dry skin or facial wrinkles; compounds that duplicate the formulation of a manufactured pharmaceutical product; and compounds that are unproven, such as drugs intended for oral use that are compounded into a topical mixture.
5. All amounts stated in this policy are in Canadian funds.
6. If eligible 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. You agree to fully cooperate with *GMS* in any action that might be taken.
7. 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*.
8. Benefits are payable only for amounts in excess of what would normally be payable under *government plans* as they exist as of the *policy effective date* of this policy. There is no coverage for any benefits of any nature, which were provided by a *government plan* on the *policy 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.
9. In the event that you have concurrent insurance from another source(s) in respect of benefits provided under this policy, benefits shall be co-ordinated with your other insurer(s) as follows:
 - a) All benefits from any *government plan* shall be determined and recovered first;
 - b) *GMS* will pay eligible expenses only in excess of amounts covered by that of other insurer(s), including but not limited to any employment related plan, extended health care plan, private or provincial vehicle insurance, credit card policy or any other insurance, whether collectible or not;
 - c) If, however, the other source(s) of coverage is also "excess only", all benefits shall be determined and recovered from the policies based on the following priority:
 - i) any plan not containing a co-ordination of benefits statement; then
 - ii) any employment/retirement related plan; then
 - iii) any other plan, including *GMS*. In this case, the benefits shall be prorated according to the maximum amounts that would have been payable as the result of the benefit contained under the respective plans. You agree that prorated sharing is what was intended when the policy was entered into and that sharing on any other basis including on the basis of independent or several liability and/or equal sharing is not what was intended or agreed to; then
 - iv) the private plan (Individual Health Plan) where the insured person is covered as a member.
10. No benefit will be paid for or provided that is a duplication of any service, allowance or reimbursement supplied by an existing *government plan* or *private plan*.
11. When requested by *GMS*, you must apply for all publicly funded support programs that exist or may come to exist during the *policy year*.
12. *GMS* is not responsible for the availability, quality, results or effectiveness of any medical *treatment* or transportation or your failure to obtain medical *treatment*.
13. No payment will be provided for expenses resulting directly or indirectly from the commission or attempted commission of any criminal, criminal-like or illegal activity; intentional self-injury, suicide or attempted suicide; the consumption or abuse of any alcohol, medication or drugs, or any event, act or omission caused or contributed to by the use or abuse of alcohol, medication or drugs; any participation in the armed forces; or any willful exposure to peril.
14. No benefit will be provided for expenses incurred as a result of a motor vehicle *accident*, unless such services are not covered by any other private or public vehicle insurance.
15. No benefit will be provided for expenses resulting from participation in professional sports, any speed contest, SCUBA diving (unless PADI, ACUC or SSI certified) extreme sports including but not limited to: parachuting, mountaineering, skydiving, rodeo, hang gliding, bungee cord jumping, acrobatic or stunt flying, or a flight *accident* unless riding as a passenger on a commercially licensed airline.
16. 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.
17. 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.
18. By purchasing this policy you are authorizing:
 - a) 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*, examination, diagnosis and/or services rendered to you or any of your *dependants*.
 - b) *GMS* to collect, store and use any information which is provided by you and any information obtained pursuant to clauses a) and c).

V. HOSPITAL CASH

A. Hospital Cash Benefit

If you have purchased the Hospital Cash *additional coverage option*, the following benefit is available:

If you are confined to a *hospital* due to *accident* or illness, on an in-patient basis, undergoing active *treatment*, payment of \$100 per day, up to thirty (30) consecutive days of hospitalization. Coverage commences on the 4th day of hospitalization or on the 7th day of hospitalization due to pregnancy or childbirth. You must be released from the *hospital* for a minimum of sixty (60) days before a subsequent claim can be made for the same diagnosis or illness.

B. Hospital Cash Exclusions and Limitations

The following exclusions and limitations apply to the Hospital Cash benefits:

1. The *benefit effective date* of this benefit must precede the *hospital* admittance date.
2. This benefit is not available for *hospital* stays for conditions in which you are awaiting, waitlisted or scheduled for hospitalization or surgery at the time of application for Hospital Cash Benefits. If you were diagnosed with cancer in the 24 months prior to your application for this plan option you will not be covered for any cancer-related *hospital* stays.
3. Benefits for this policy will not apply to newborn children until after they have been released from the *hospital* following birth, they are added to the policy and the appropriate premiums are paid.
4. In calculating the number of days in respect of coverage, the day of admission shall be counted as one day, but the day of discharge shall not be counted unless it is also the day of admission.
5. This benefit is only payable when you are hospitalized within Canada.
6. When making a Hospital Cash Benefit claim *GMS* requires the official discharge papers from the *hospital* stating the admission and discharge dates, as well as a diagnosis by your *physician* in regards to your admission to the *hospital*.
7. No benefit will be paid for or provided that is a duplication of any service, allowance or reimbursement supplied by an existing *government plan* or *private plan*.
8. When requested by *GMS*, you must apply for all publicly funded support programs that exist or may come to exist during the *policy year*.
9. *GMS* is not responsible for the availability, quality, results or effectiveness of any medical *treatment* or transportation or your failure to obtain medical *treatment*.
10. No payment will be provided for expenses resulting directly or indirectly from the commission or attempted commission of any criminal, criminal-like or illegal activity; intentional self-injury, suicide or attempted suicide; the consumption or abuse of any alcohol, medication or drugs, or any event, act or omission caused or contributed to by the use or abuse of alcohol, medication or drugs; any participation in the armed forces; or any willful exposure to peril.
11. No benefit will be provided for expenses incurred as a result of a motor vehicle *accident*, unless such services are not covered by any other private or public vehicle insurance.
12. No benefit will be provided for expenses resulting from participation in professional sports, any speed contest, SCUBA diving (unless PADI, ACUC or SSI certified) extreme sports including but not limited to: parachuting, mountaineering, skydiving, rodeo, hang gliding, bungee cord jumping, acrobatic or stunt flying, or a flight *accident* unless riding as a passenger on a commercially licensed airline.
13. 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.
14. 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.
15. By purchasing this policy you are authorizing:
 - a) 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*, examination, diagnosis and/or services rendered to you or any of your *dependants*.
 - b) *GMS* to collect, store and use any information which is provided by you and any information obtained pursuant to clauses a) and c).

VII. GENERAL TERMS AND CONDITIONS

The following terms and conditions apply to all benefits and coverage under this policy, including all health plan options and *additional coverage options*:

1. Enrolment is open to any person on a *single*, *couple* or *family* basis, who has valid health coverage from their *province of residence*, and who remains in their *province of residence* for a minimum of one hundred and eighty (180) days of each calendar year.
2. A *family* contract is limited to six individuals, consisting of two (2) parents with four (4) *dependants* or one (1) parent with five (5) *dependants*.
3. *GMS* must be notified within thirty (30) days in order to add a newborn to the policy from their date of birth. If not notified within that time frame, coverage is effective on the date of notification.
4. You may upgrade your health plan option or add additional coverage for Annual Travel, Dental Care, Prescription Drugs, or Hospital Cash to your health plan at any time during the *policy year* and this additional coverage will be added on to your health plan for the remaining term of the *policy year*. Reimbursement for claims for the additional benefits purchased will be prorated for the remaining term of the *policy year*.
5. *GMS* reserves the right to individually establish or amend premium rates, benefit provisions, and/or terms and conditions upon application or renewal or with thirty (30) days advance notice.

- c) *GMS* to obtain information from, or disclose information to any *government 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 our ability to administer your plan. Further, if you withdraw your consent, we may not be able to offer you our products and services and you will limit our ability to pay your claim(s).
20. 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.
 21. This policy shall be interpreted and construed in accordance with the law of the Province of Saskatchewan and the federal law of Canada applicable therein, and the parties hereby attorn to the non-exclusive jurisdiction of the Courts of the Province of Saskatchewan.
 22. *GMS* reserves the right to suspend claims reimbursement until such time as payment of premiums in full is received.
 23. In the event of non-payment of premiums, *GMS* reserves the right to terminate the policy.
 24. You may terminate the policy as provided for in the following statutory conditions. Termination shall take effect on the latter of the date the notice is received by *GMS* at its head office or the date specified in the letter of termination. *GMS* reserves the right to apply a contract termination fee. Following the date of termination, the *policyholder* and/or any persons covered under the policy will not be eligible for any reimbursement of claims under the policy, regardless of the date on which the claim was incurred.
 25. Individuals failing to provide payment for the policy within one (1) month of the renewal will automatically have their policy terminated. Terminated policies may be reviewed and reinstated within two (2) months of the renewal date.
 26. The following conditions apply for reimbursement of a claim:
 - a) *GMS* requires a completed claim form, original itemized receipts including name, date and details of service, as well as *physician* referral, when making a claim.
 - b) A *GMS* claim form or a standard dental claim form must be completed and submitted when making a dental claim, with the following information: your name, *GMS* number, address and phone number, date and details of the service(s).
 - c) All claims must be submitted within twelve (12) months of the date of service in order to be eligible for reimbursement. However, if the policy has expired, any claim must be submitted to *GMS* within thirty (30) days following the expiry date.
 - d) Any action brought against *GMS* to recover on this policy must be brought within twelve (12) months from the date the claim form was first submitted.
 - e) *GMS* may pay part or all of the benefit directly to the provider of the service.
- authorized agent of *GMS*, and *GMS* shall upon surrender of this policy refund the amount of premium paid in excess of the short rate premium calculated to the date of receipt of such notice according to the table used by *GMS* at the time of termination.
6. Termination By *GMS*
 - a) *GMS* may terminate this policy at any time by giving written notice of termination to the *policyholder* and by refunding concurrently with the giving of notice the amount of premium paid in excess of the pro rata premium for the expired time.
 - b) The notice of termination may be delivered to you, or it may be sent by registered mail to your latest address as shown on the records of *GMS*.
 - c) Where the notice of termination is delivered to you, five days' notice of termination shall be given; where it is mailed to you, 10 days' notice of termination shall be given, and the 10 days shall begin on the day following the date of mailing of notice.
 7. No refund will be issued for any amounts under \$5.
 8. Notice and Proof of Claim
 - a) You, or a beneficiary entitled to make a claim shall:
 - i) give written notice of the claim to *GMS*:
 - (A) by delivery thereof, or by sending it by registered mail to the head office of *GMS* in the province of Saskatchewan; or
 - (B) by delivery thereof to an authorized agent of *GMS* not later than 30 days from the date a claim arises under the policy on account of an *accident* or sickness;
 - ii) within 30 days from the date a claim arises under the policy on account of an *accident* or sickness, furnish to *GMS* such proof as is reasonably possible in the circumstances of the happening of the *accident* or the commencement of the sickness, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the beneficiary, if relevant; and
 - iii) if so required by *GMS*, furnish a satisfactory certificate as to the cause or nature of the *accident* or sickness for which claim may be made under the policy.
 - b) Failure to give notice of claim or furnish proof of claim within the time prescribed by this condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one (1) year from the date of the *accident* or the date a claim arises under the policy on account of sickness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.
 9. Insurer to Furnish Forms for Proof of Claim
 - a) *GMS* shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time he or she may submit his or her proof of claim in the form of a written statement of the cause or nature of the *accident* or sickness giving rise to the claim and of the extent of the loss.
 10. Rights of Examination
 - a) As a condition precedent to recovery of insurance monies under this policy:
 - i) You shall afford to *GMS* an opportunity to examine your person when and so often as *GMS* reasonably requires while the claim hereunder is pending; and
 - ii) In the case of death of the person insured, *GMS* may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.
 11. Money Payable
 - a) All monies payable under this policy shall be paid by *GMS* within 60 days after satisfactory proof of claim has been received and accepted by *GMS*.

VIII. STATUTORY CONDITIONS

1. Policy
 - a) The application, this policy, any document attached to this policy when issued, and any amendments to the policy agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has the authority to change the contract or waive any of its provisions.
2. Waiver
 - a) *GMS* shall be deemed not to have waived any condition of this policy, either in whole or in part, unless the waiver is clearly expressed in writing signed by *GMS*.
3. Copy of Application
 - a) *GMS* shall, upon request, furnish to the *policyholder* or to a claimant under the policy a copy of the application.
4. Material Facts
 - a) No statement made by *GMS* or the *policyholder* at the time of application for this policy shall be used in defense of a claim under or to avoid this policy unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.
5. Termination By the *Policyholder*:
 - a) The *policyholder* may cancel the entire policy at any time during the *policy year* by giving written notice of termination to *GMS* by registered mail, mail, fax or email to its head office, or delivery thereof to an

IX. DEFINITIONS

Some words in this policy have very specific meanings, which are set out in this Definitions section. These words appear in *italics* throughout the policy document. The following definitions apply to all options and *additional coverage options*.

Accident/Accidental: a happening due to external, sudden, fortuitous causes beyond your control.

Additional coverage options: travel benefits, 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.

Couple: consists of two (2) people living in a spousal relationship or a parent and a dependant.

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

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

Departure point: the province, territory, or country you depart from on the first day of your intended travel period.

Dependant: any unmarried child of you or your spouse (including step-child, adopted child, or a child for 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) eighteen (18) years of age and under; or
- b) twenty-four (24) years of age and under if the child is undergoing full-time student educational training: i) in Canada, for coverage under OmniPlan®, or ii) in your province of residence, for coverage under ExtendaPlan® and BasicPlan; or
- c) a developmentally or physically disabled child, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the child attaining the ages indicated above to ensure continuing eligibility.

Emergency: a sudden or urgent happening that is acute and poses an immediate risk, requiring immediate medical intervention and/or treatment. In the case of an emergency incurred during your trip, an emergency no longer exists when the medical evidence indicates that no further treatment is required at your destination, or indicates you are able to return to your province of residence for further treatment.

Family: consists of two (2) persons living in a spousal relationship with up to four (4) dependants, or one (1) parent with up to five (5) dependants.

Formulary: those prescription drugs that a provincial government includes on their provincial drug plan formulary and for which the provincial government provides cost sharing with residents of their province. The formularies vary by province.

GMS: Group Medical Services and/or its authorized agents, representatives, affiliates or other service providers.

Government 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.

Heart disease: any disease of the heart including angina, irregular heartbeat, heart attack, congestive heart failure, ischemic heart disease, valvular heart disease, and myocardialopathy.

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 legally licensed medical 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.

Immediate family member: 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.

Non-adherence: the failure or refusal of a patient to co-operate by carrying out that portion of the medical care plan under his or her control.

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.

Policy effective date: the date that the application is received at GMS's office or the office of an authorized agent of GMS. Coverage will not be effective until GMS has approved the application and received the appropriate premium.

Policyholder: the person who has applied and paid the premiums to GMS for an Individual Health Plan and whose application has been approved by GMS.

Policy year: means, for the current policy the twelve (12) months following the policy effective date, and for any previous policies, the twelve (12) months following the policy effective date for such previous policies.

Province of residence: the province that you have declared as your permanent residence and in which you reside in for a minimum of one hundred eighty (180) days per calendar year.

Reasonable and customary: charges that are reasonably comparable to those normally charged for the applicable goods or services in the particular area where the goods or service is purchased or received.

Return date: the date on which you are scheduled to return to your departure point.

Single: one (1) person.

Special status: those prescription drugs that are granted special coverage under a provincial drug formulary when a person meets certain criteria as outlined by that provincial drug formulary.

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

Stable: any medical condition or related medical condition related directly to your original condition for which:

- a) there have been no new symptoms, more frequent or more severe symptoms;
- b) there has been no change in treatment or change in medication (Any newly prescribed medication, change in medication type, increase/decrease in dosage or discontinuation of a medication constitutes a change. A change from a brand name medication to a generic brand medication of the same dosage does not constitute a change in medication);
- c) there has been no deterioration of your medical condition;
- d) there has been no hospitalization or referrals to a specialist including initial follow-up visits, tests or investigations booked in conjunction with a medical condition/symptom;
- e) there is no further testing, treatment or investigation booked or results pending;
- f) you have not experienced a symptom that remains undiagnosed; and
- g) no further medical treatment after departure from your province of residence would be anticipated.

Surgeon: a physician who is licensed under the laws of the province, state or country where the services are rendered to practice surgery without restriction.

Treatment: any medical, therapeutic or diagnostic measure prescribed or recommended by a physician in any form including prescription medication, investigative testing, hospitalization, surgery or other prescribed or recommended action directly referable to the applicable condition, symptom or problem.

You or your: any person who is eligible for coverage for any benefit under this policy.

If your plan includes travel coverage:

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

toll-free 1.800.459.6604

(within Canada & USA)

collect 416.260.4970

(from all other locations)



Group Medical Services

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