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

HEALTH

A. Health Benefits

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

1. Eye Exams

This benefit provides payment for eye examinations, including refractions. Eye examinations related to surgical procedures or any form of optical surgery are excluded.

OmniPlan
$75 maximum per person in the two (2) most recent *policy years*, including the current *policy year*

2. Eyeglasses and Contact Lenses

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

OmniPlan
$200 maximum per person in the two (2) most recent *policy years*, including the current *policy year*

3. Health Practitioners

This benefit provides payment for the cost 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. *GMS* will only cover one type of *treatment* within the scope of practice for each individual practitioner.

Treatments by a massage therapist, physiotherapist or psychologist require the written referral of a *physician* each *policy year*. Diagnostic and investigative testing is excluded.

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

4. Hearing Aids

This benefit provides payment for hearing aids fitted by an audiologist or an audiogram conducted by an audiologist.

Hearing tests, hearing aid fitting services, batteries and additional or replacement ear moulds are excluded.

Reimbursement under this benefit is subject to a waiting period of one (1) full year of enrolment in the plan.

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

5. Health Supplies and Equipment

This benefit provides payment for the following supplies and equipment: purchase or rental of splints, braces containing metal or hard plastic components; and purchase of wigs, trusses, rib belts, air casts, clavicle straps, cervical collars, shoulder immobilizers, sacroiliac corsets, embolic stockings (maximum of four (4) pair per person per *policy year*), and aero chambers.

A *physician* must prescribe each of the above items in writing for coverage to apply.

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

6. Diabetic Supplies and Equipment

This benefit provides payment for the purchase of diabetic supplies and equipment, including testing devices, when ordered in writing by a *physician* for use in the home.

Insulin and other prescription medications are excluded.

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

7. Oxygen Equipment

This benefit provides 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.

CPAP machines and the cost of oxygen are excluded.

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

8. Blood Pressure Monitors

This benefit provides payment for the purchase of a blood pressure monitor when ordered in writing by a *physician* for personal use in the home.

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

9. Custom Made Foot Orthotics

This benefit provides payment of 80% of the purchase of custom made foot orthotics, up to a maximum benefit reimbursement as provided by *your* plan as outlined below.

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 impression, plaster casting and direct mould.

The cost of assessment, casting or scanning is excluded.

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

10. Therapeutic Shoes

This benefit provides 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.

Sandals, runners or boots, or any shoes that have pointed toes are excluded.

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

11. Mobility Aids

This benefit provides payment for the following mobility aids: canes, reaching aids, raised toilet seats, grab bars, bathtub/toilet safety rails, and bathtub/transfer benches.

Receipts must be accompanied by a *physician*'s letter confirming necessity and that they are intended for personal use in the home. Canes and reaching aids will also be reimbursed if used in personal care homes and nursing homes.

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

12. Ostomy Supplies

This benefit provides payment for ostomy supplies when required for use in the home.

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

13. Funeral Expenses

This benefit provides payment for funeral expenses provided the death is *accidental* and not the result of sickness or disease, either as cause or effect.

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

OmniPlan
$4,000 maximum per person

14. Out-of-Province Referral

This benefit provides payment for *physician*, anaesthetic, radiology, laboratory, *hospital* and ambulance services outside *your province of residence* for *treatment* which is not available in *your province of residence*, when recommended in writing by a specialist *physician*.

The claim must have prior written approval from *GMS*. *GMS* will not approve payment for *treatment* where there are provincially funded *treatment* options 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.

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

15. Ambulance

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

Road ambulance transport returning *you* to *your* place of permanent residence, if bedridden at the time of discharge, will be reimbursed up to 50% of the cost.

Payment for transportation to *physicians*' offices and medical clinics is excluded.

OmniPlan	ExtendaPlan	BasicPlan
Unlimited	Unlimited	$2,000

16. Air Ambulance

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

The service must occur within *your province of residence* and must have prior *GMS* approval.

OmniPlan	ExtendaPlan	BasicPlan
Unlimited	Unlimited	Unlimited

17. Casts and Crutches

This benefit provides payment of the cost for fibreglass casts and for the purchase or rental of crutches.

OmniPlan	ExtendaPlan	BasicPlan
Unlimited	Unlimited	Unlimited

18. Preferred Hospital Room

This benefit provides reimbursement of private or semi-private *hospital* room costs. The *benefit effective date* must precede the *hospital* admittance date. Stays for convalescent and respite care are excluded.

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

19. Private Duty Nursing

This benefit provides payment of 80% of private duty nursing costs up to a maximum benefit reimbursement as provided by *your* plan as outlined below.

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

Nursing services rendered in licensed institutional-type facilities are excluded. The *benefit effective date* must precede the *hospital* admittance date.

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

20. In-Hospital Drugs

This benefit provides 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.

Fertility drugs, drugs for *treatment* of sexual dysfunction, lifestyle drugs, experimental drugs, diet drugs, drugs used for cosmetic purposes, drugs normally available over the counter and drugs used for the cessation of smoking are excluded.

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

21. Accidental Injury to Natural Teeth

This benefit provides 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.

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 totalling $500 or more must have prior approval from *GMS*. All services must be completed within twelve (12) months of the date of injury.

Dental implants are excluded.

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

22. Wheelchairs, Motorized Scooters and Adjustable Beds

This benefit provides 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*. Reimbursement under this benefit is subject to a waiting period of one (1) full year of enrolment in the plan.

Adjustable beds for individuals 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 personal care home are excluded.

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

23. Artificial Limbs, Eyes and Larynx

This benefit provides payment for the purchase of artificial limbs, eyes and/or larynx.

Myoelectric limbs are excluded.

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

24. Patient Walkers

This benefit provides payment of 80% of the cost to purchase or rent patient walkers, up to a maximum benefit reimbursement as provided by *your* plan as outlined below.

A written *physician*'s referral is required.

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

25. Breast Prosthesis

This benefit provides payment for the purchase of an artificial breast prosthesis.

A written *physician*'s referral is required for bilateral mastectomy patients.

Surgical brassieres are excluded.

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

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. Vision goods may be purchased worldwide. Reimbursement will be based on the lowest of either the purchase price or the available price within *your province of residence*.
3. Reimbursement for goods and services is based on Canadian currency.
4. For BasicPlan and ExtendaPlan, services must be provided within *your province of residence*. For OmniPlan, services may be provided anywhere within Canada.

ADDITIONAL COVERAGE OPTIONS

The following lists eligible benefits provided for in *GMS*'s Annual Travel, Dental Care, Prescription Drug, Prescription Drug Enhanced and Hospital Cash *additional coverage options*. These options can be added to *your* OmniPlan, ExtendaPlan or BasicPlan for an additional premium.

ANNUAL TRAVEL

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 or limitations.
- A pre-existing medical exclusion applies to medical conditions and/or symptoms that existed prior to *your* travel. Check the policy to see how this applies to *you*.
- Should any changes in *your* health occur after the application date and prior to the *effective date*, *GMS* must be contacted and the application updated.
- In the event of an *accident*, injury or sickness, *your* prior medical history may be reviewed when a claim is reported.
- *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

If *you* have purchased the Annual Travel additional coverage option, the following travel benefits are available.

Travel benefits are 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 is subject to certain exclusions and limitations.

A. Travel Benefits

Travel benefits include:

1. **Hospitalization** - provides payment for *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** - provides payment for *treatment* by a *physician* or *surgeon*.
3. **Diagnostic Services** - provides payment for 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** - provides payment for out-patient *emergency* room expenses.
5. **Prescription Drugs** - provides payment for 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 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.
6. **Private Duty Nursing** - provides payment, 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** - covers 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** - provides payment 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. Helicopter transport is excluded.
9. **Remote Evacuation** - provides payment, 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** - provides payment for 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** - provides payment for 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** - provides payment, up to an aggregated maximum of $300 per person, for the *emergency* services of an osteopath, physiotherapist, chiropractor, chiropodist and/or podiatrist.
13. **Accidental Dental** - provides payment 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; and expenses for *treatment* to relieve dental pain, to a maximum of $250 for such *treatment*. Dental implants are excluded.
14. **Return of Remains** - when death results from a covered *emergency*, this benefit provides payment for the expenses for either the preparation or 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** - provides payment for 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 (3) 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. Pre-approval by *GMS* is required.

    In addition, reimbursement of up to $150 per day, to a maximum of $750, is provided for *reasonable and customary* expenses incurred by the transported person once they arrive. Original paid receipts for the expense incurred are required.
16. **Family Transportation** - when death results from a covered *emergency*, payment is provided for a *single* round-trip economy class airfare for an *immediate family member*, plus up to $300 for meals and accommodations, to an aggregate maximum of $2,000 to identify the deceased. This benefit must be pre-approved by *GMS*.
17. **Return of Vehicle** - provides payment, to a maximum of $2,000, 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. Pre-approval is required by *GMS* and the 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 the 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, for licensed care of dependent children if they are traveling with *you*, should *you* be hospitalized due to medical *emergency*. Pre-approval by *GMS* is required.
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*. Pre-approval by *GMS* is required.
21. **Coverage Continuation** - if coverage expires while *you* are hospitalized due to an *emergency*, applicable coverage will continue for *you*, *your spouse* and any *dependant* 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 on *your* scheduled *return date*. Original paid receipts for the expenses incurred and pre-approval by *GMS* required.
23. **24-Hour Travel Assistance Services** - 1.800.459.6604 (within Canada & US) or 905.762.5196 (collect from other locations)
    a. Co-ordination of medical care, transportation, and repatriation
    b. Telephone interpretation services in most languages
    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 payable of $2,000,000, subject to the maximum benefit limits described in Part 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 only eligible for travel benefits 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 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 and within the first fifteen (15), thirty (30), or forty-eight (48) days after leaving Canada. The number of days per trip depends on the Annual Travel option *you* have chosen.
4. *You* must purchase the travel plan 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 the 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 (2) 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 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. Travel coverage has no waiting period.
13. 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 *GMS* TravelStar® Travel Insurance. *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 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 stability period specified in b. or c. below; or
   ii. if at any time during the stability period specified in b. or c. below:
      - any heart condition has not been *stable*; or
      - any lung condition has not been *stable*.
b. A 365 day stability period will apply immediately prior to *your departure date* from *your province of residence* to all of *your* pre-existing medical conditions, regardless of *your* age, if any of the following apply to *you*:
   i. *you* use home oxygen for heart and/or lung disease;
   ii. *you* have undiagnosed episodes of syncope/fainting or falling;
   iii. *you* have kidney failure;
   iv. *you* have both *heart disease* and insulin dependent diabetes and are taking medication for both; or
   v. *you* have congestive heart failure.
c. If any of the listed medical conditions in 1b. above do not apply to *you*, all *your* pre-existing medical conditions must be *stable* for:
   i. 90 days immediately prior to *your* departure date from *your province of residence* for all individuals age 69 or younger; or
   ii. 180 days immediately prior to *your* departure date from *your province of residence* for all individuals age 70 and older.

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. expenses that are a duplication of any service, allowance or reimbursement supplied by an existing *government plan* or private plan;
   f. expenses for 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*;
   g. expenses for *treatment* at a diagnostic facility unless pre-approved by *GMS*;
   h. expenses for *emergency* air transportation or return to *province of residence*, which is not arranged and pre-approved by *GMS*;
   i. 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;
   j. 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;
   k. expenses related to transplants at *your* destination, including but not limited to organ transplants, bone marrow or stem cell transplants;
   l. any expenses incurred where 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*;
   m. expenses resulting when travel is booked or commenced contrary to medical advice;
   n. expenses related to pregnancy, miscarriage, childbirth or complications of any of these conditions occurring after the first eighteen (18) weeks of pregnancy;
   o. expenses for routine or general physical examinations, checkups or services of a continued nature following *emergency treatment* of a sickness or injury;
   p. expenses related to 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*;
   q. expenses for any endovascular surgical procedures, either done individually or in combination with conventional surgical procedures;
   r. expenses incurred as a result of a motor vehicle *accident*, unless such services are not covered by any other public or private vehicle insurance;
   s. expenses resulting from participation in professional sports, any speed contest, SCUBA diving (unless NAUI, 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.
   t. expenses for any *treatment* which is considered by *GMS* to be experimental (*GMS*'s opinion on the issue is final and binding);
   u. expenses for *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*;
   v. expenses for persons holding a work visa from the country to which they are travelling while working; or for persons who are working in hazardous occupations; and
   w. 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.

DENTAL CARE

If *you* have purchased the Dental Care additional coverage option, the following dental care benefits are available within Canada, based on the *Dental Fee Guide* within *your province of residence*.

A. Dental Care Benefits

1. **1st *policy year*** – 75% of eligible charges for Basic Dental Services, to a maximum of $500 per person per *policy year*. Waiting period applies.

   2nd *policy year* – 80% of eligible charges for Basic Dental Services and 50% of eligible charges for Major Dental Services, to a combined maximum of $750 per person per *policy year*.

   3rd *policy year* – 80% of eligible Basic Dental Services and 50% of 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 year*s;
   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:
      i. one of either a complete series or panoramic x-ray per three (3) *policy year*s
      ii. intra-oral and extra-oral x-rays to a maximum of ten (10) films per two (2) *policy year*s;
   d. *treatment* planning and consultation;
   e. diagnostic casts once per three (3) *policy year*s;
   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) times 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 dependent children under eighteen (18) years of age;
   k. protective mouth guards, one (1) per *policy year* for dependent children under sixteen (16) years of age and one (1) per three (3) *policy year*s 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 disking 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 year*s;
   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 year*s per arch;
   u. denture remakes, when a replacement partial denture would be eligible for coverage;
   v. fixed prosthodontics repairs including replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, re-cementation, and fixed bridge/prosthesis repairs;
   w. basic oral surgery including erupted teeth extractons, surgical extractions, surgical excisions, surgical incisions, and post-surgical care;
   x. anaesthesia; and
   y. dental appliances for the control of oral habits (including Bruxism); one (1) per *policy year* for dependent children under sixteen (16) years of age and one (1) per three (3) *policy year*s 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; replacement must be separated by at least five (5) *policy year*s;
   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; if there were three or more teeth missing prior to *you* becoming eligible for coverage under this policy, *GMS* will pay for a partial denture only; and
f. replacement bridge pontics and fixed bridge retainers on teeth extracted while *you* are covered under this plan, or if the existing bridge pontics or fixed bridge retainer is at least five (5) years old.

B. Dental Care Exclusions and Limitations

The following exclusions and limitations apply to Dental Care benefits.

1. 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. *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. 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.
8. Where an examination has been performed that identifies *necessary and adequate* dental services, *GMS* will pay for the examination fee and the *necessary and adequate* dental services as covered under the policy. Fees for secondary dental examinations during the *treatment* of the diagnosed dental services will not be covered.
9. Multiple restorations submitted on the same tooth will be limited according to *reasonable and customary* charges as indicated in the *Dental Fee Guide*.
10. 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.
11. 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;
    c. expenses associated with congenital defects, developmental malformations or temporomandibular joint disorders;
    d. expenses for implants or crowns involved in an implant procedure and surgical insertion;
    e. expenses for the replacement of lost or stolen dentures;
    f. expenses incurred to increase vertical dimension and repair or restore teeth damaged or worn due to attrition or vertical wear; and
    g. expenses for tissue grafts.

PRESCRIPTION DRUGS

If *you* have purchased a prescription drug additional coverage option, *GMS* will provide payment for the following benefits within *your province of residence*.

A. Prescription Drug Benefits

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*;
   b. payment for oral contraceptives listed in *your* provincial *formulary* when purchased in *your province of residence*; and
   c. payment up to $500 per person per *policy year* for prescription medication:
      i. for any pre-existing medical condition at the time of application; and
      ii. *special status* drugs and all medications that legally require a prescription by law.

   Claims will be adjudicated based on the *province of residence formulary*. For provinces that do not have a provincial *formulary*, claims will be adjudicated using 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.
3. For each eligible prescription which is purchased, *you* are responsible for a $4 charge per prescription, whether submitted using *your GMS* pay-direct card or by manual submission to *GMS*.

B. Prescription Drug Exclusions and Limitations

The following exclusions and limitations apply to 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.

HOSPITAL CASH

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

A. Hospital Cash Benefit

This benefit provides payment of $100 per day if *you* are confined to a *hospital* and undergoing active *treatment* on an in-patient basis due to *accident* or illness.

Coverage commences on the 4th day of hospitalization or on the 7th day of hospitalization due to pregnancy or childbirth. This benefit provides for a maximum of 30 (thirty) consecutive days of in-patient hospitalization.

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 benefit.

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, wait listed or scheduled for hospitalization or surgery at the time of application for Hospital Cash benefits. If *you* were diagnosed with cancer in the twenty-four (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*.

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 (6) individuals consisting of two (2) parents with four (4) *dependant*s or one (1) parent and five (5) *dependant*s. Additional *family* members may be added, subject to an additional fee for each additional *family* member to be insured.
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* have ten (10) days from the day *you* apply for *your* policy to return it to *GMS* for cancellation. The policy will be considered null and void and any premium paid up to the end of the 10-day examination period will be refunded, provided no claim has been incurred. If a claim has been paid, the amount must be repaid to GMS less the premium amount immediately before the policy will be deemed null and void. This period of examination expires ten (10) days after *you* apply for *your* policy and have received a copy of the policy contract. All other requests for termination are subject to the conditions provided for in the Statutory Conditions section.
5. *You* may upgrade *your* health plan option or add additional coverage for dental care, prescription drugs, or Hospital Cash to *your* health plan at any time during the *policy year*. The additional coverage will be added on to *your* health plan for the remaining term of the *policy year*. Reimbursement for claims for the additional benefits purchased will be prorated for the remaining term of the *policy year*.
6. *You* may downgrade *your* health care benefits at *your* renewal. Written notice should be sent to *GMS* requesting the change. The coverage being downgraded must have been in-force for a minimum of twelve (12) months before *GMS* will allow the downgrade.
7. *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.
8. All amounts stated in this policy are in Canadian funds.
9. 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.
10. 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 plan*s 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.
11. 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.
12. 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.
13. When requested by *GMS*, *you* must apply for all publicly funded support programs that exist or may come to exist during the *policy year*.
14. *GMS* is not responsible for the availability, quality, results or effectiveness of any medical *treatment* or transportation or *your* failure to obtain medical *treatment*.
15. 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; pre-existing *mental illness*; 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.
16. 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.
17. No benefit will be provided for expenses resulting from participation in professional sports; any speed contest; SCUBA diving (unless NAUI, 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.
18. Any material misrepresentation, provision of incorrect information or nondisclosure of information by *you* will result in non-payment of any claim and will void *your* coverage.
19. 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.
20. 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 dependant*s.
    b. *GMS* to collect store and use any information which is provided by *you* and any information obtained pursuant to clauses a. and c.
    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 *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).
21. As provided for under Section 102 of the Insurance Act *you* may, by contract or declaration, designate the insured, the insured's personal representative or a beneficiary as a person to whom insurance money is to be payable by providing written notice to *GMS* of such designation. Designations made through the insurance contract shall be deemed to be revocable and shall be in effect until *you* alter or revoke the designation in writing. *GMS* reserves the right to restrict or exclude *your* right to designate persons to whom insurance money is payable.
22. *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.
23. 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.
24. *GMS* reserves the right to suspend claims reimbursement until such time as payment of premiums in full is received.

    In the event of non-payment of premiums, *GMS* reserves the right to terminate the policy with notice. Failure to provide payment of a policy renewal offer within one (1) month of the offer will result in *GMS* terminating the policy with notice. Terminated policies may be reinstated within two (2) months of the termination date.

25. *You* may terminate the policy as provided for in the Statutory Conditions. Termination shall take effect based on one of the following:
    a. the day preceding the next scheduled monthly withdrawal date, where a full month of coverage has expired; or
    b. the day proceeding the last day of the expiry of a full month of coverage.

    Following the *effective date* of the termination, no further claim will be paid, regardless of the date on which the claim was incurred.
26. Following a termination by the *policyholder*, re-application for an individual health product with *GMS* is restricted for a two (2) year waiting period unless one of the following reasons for termination apply:
    a. the new application is medically underwritten before acceptance; or
    b. the original termination was requested for one of the following conditions:
        i. coverage was replaced by a new group health policy, without a lapse;
        ii. coverage was replaced by a new Individual Health policy, without a lapse; or
        iii. termination was requested due to death, separation or divorce from an insured *spouse* and new coverage is applied for with *GMS*, without a lapse.
27. 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.
28. Every action or proceeding against an insurer for the recovery of insurance money payable under the contract 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.

HOW TO MAKE A CLAIM

A. Making a Claim

The following terms and conditions apply for reimbursement of a claim, in addition to the statutory conditions, and apply to claims made under all benefits and coverage under this policy, including all health and travel plan options and *additional coverage options*. Some benefits require pre-approval by *GMS* or written referrals from qualified *physician*s for coverage to apply. Please refer to each benefit for specifics.

1. *GMS* requires a completed claim form, original itemized receipts including name, date and details of service, as well as *physician* referral (if applicable), when making a claim.
2. A *GMS* claim form or a standard dental claim form must be completed and submitted when making a dental claim, and include the following information: *your* name, *GMS* number, address and phone number, date and details of the service(s).
3. *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*, when making a claim for the Hospital Cash benefit.
4. 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.
5. Claims for benefits under Annual Travel require the following.
    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.
6. *GMS* may pay part or all of the benefit directly to the provider of the service.

STATUTORY CONDITIONS

1. **The contract**

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

    Waiver

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

    Copy of application

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

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

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

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

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

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

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

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

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

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

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

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

    (ii) by delivery thereof to an authorized agent of the insurer in the province;

    not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability;

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

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

    Failure to give notice of proof

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

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

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

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

    (b) in the case of death of the person insured, the insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.
10. **When moneys payable other than for loss of time**

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

DEFINITIONS

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 health plan options and *additional coverage options*.

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

Additional coverage options: Annual 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 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. 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.

Effective date: is the later of the following:

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

Policies are issued on either the 1st or 15th of the month.

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) *dependant*s or one (1) parent with up to five (5) *dependant*s.

Formulary: those approved prescription drugs that a provincial government includes on its provincial drug plan and for which the provincial government provides cost sharing with residents of the 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 myocardiopathy.

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 *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.

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.

Mental Illness: any of various psychiatric conditions, usually characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by physiological or psychosocial factors. Also called mental disease, mental disorder.

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

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.

Policyholder: a person in whose favour an insurance policy is issued.

Policy year: means, for the current policy the 365 days following the *policy effective date*, and for any previous policies, the 365 days following the *policy effective date* for such previous policies.

Pro rata: refers to the exact proportion of the *policy year* used. As it refers to premium refund, it is the exact proportion of the premium which has not yet been used.

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 services are 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 (*);
c. A dosage adjustment of an anti-hypertensive or cholesterol lowering medication done in the pre-existing timeframe does not constitute a change;
d. there has been no deterioration of *your* medical condition;
e. 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;
f. there is no further testing, *treatment* or investigation booked or results pending;
g. *you* have not experienced a symptom that remains undiagnosed; and
h. no further medical *treatment* after departure from *your province of residence* would be anticipated.

(*) Any newly prescribed medication, change in medication type, increase/decrease in dosage or discontinuation of a medication constitutes a change. It does not include a change from a brand name medication to a generic brand medication of the same dosage. If *you* are taking Coumadin/Warfarin for anticoagulation therapy or are insulin dependent or take oral medication for diabetes and are required to have *your* blood levels tested on a regular basis and *your* medical condition remains unchanged, yet *you* are required to adjust the dosage of *your* medication only to ensure correct blood levels are maintained, this is not considered a change in medication, except for an adjustment (stop and start) in an anticoagulation medication dosage due to surgery within ten (10) days prior to *your departure date* or, if used as a top-up, on the *effective date*, constitute a change.

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* or *dentist* in any form including prescription medication, investigative testing, hospitalization, surgery or other prescribed 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.

Products available for purchase in the provinces of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia and Newfoundland

® OmniPlan and ExtendaPlan are registered trademarks of Group Medical Services.
Group Medical Services is the operating name of *GMS* Insurance Inc. in provinces outside of Saskatchewan.