

Individual Health



health • drugs • dental • travel • hospital cash



Group Medical Services

looking after you and the ones you love

It's about... *peace of mind*

Canadians have relied on Group Medical Services as their trusted health benefits provider since 1949. We help protect you and your family with flexible and affordable health insurance that supplements your provincial health plan.

It's about... *choice*

With GMS, you're free to design the health plan that best meets your family's unique needs. Combine a health option with dental, drug and hospital cash coverage. From basic emergency services to comprehensive health benefit packages, you'll find Individual Health from GMS is the right choice for your family.

It's about... *value*

GMS is Canada's health insurance value leader, with affordable rates and the flexibility to choose the coverage you need.

It's about... *service*

At Group Medical Services, customer service is our specialty. Our experienced claims department will process your claims quickly, often in fewer than three business days from the date received. When you use our pay-direct card with participating pharmacists your claims are processed automatically – no need to submit your receipts.

If you have any questions about your health plan, you can always call GMS Customer Care toll-free at 1-800-667-3699 and talk with a friendly representative.

Protect Your Family with an
Individual Health Plan
from Group Medical Services

Select the health plan and any combination of additional coverage options that best fit your life. You can add new coverage options each year when you renew your plan.

Your Health Plan Options

OmniPlan®

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

ExtendaPlan®

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

BasicPlan

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

Additional Coverage Options

Prescription Drug

Coverage for prescription drugs listed under your provincial drug plan up to \$3,500 per person, per year. Pay only \$4.00 for each eligible prescription. Use our convenient pay-direct card and reduce out-of-pocket expenses.

Prescription Drug - Enhanced

Coverage for prescription drugs listed under your provincial drug plan, including oral contraceptives, up to \$5,000 per person, per year. Includes up to \$500 coverage, per person, per year for prescription medications for pre-existing medical conditions and legal prescriptions for medications not listed under your provincial drug plan (including special status drugs). Pay only \$4.00 for each eligible prescription. Use our convenient pay-direct card.

Dental Care

Coverage for basic procedures (oral exams, polishing, fillings) and major services including crowns, bridges, dentures, inlays and onlays, up to \$1,000 per person, per policy year.

Hospital Cash

Daily cash allowance of \$100 per day to enhance your personal comfort while in hospital. Up to 30 consecutive days of coverage.

Annual Travel

Emergency medical travel coverage for multiple trips per year. Up to 180 days per trip in Canada. For those under 80 years of age, up to \$2 million coverage for out-of-Canada travel, with your choice of 15, 30 or 48 days per trip.

Benefits	OmniPlan®	ExtendaPlan®	BasicPlan
Goods & Services	Goods and services may be purchased anywhere in Canada.	Goods may be purchased anywhere in Canada. Services must be received in your province of residence.	Goods may be purchased anywhere in Canada. Services must be received in your province of residence.
Eye Exams	\$75/2 years	n/a	n/a
Eye Glasses, Contacts, Laser Surgery	\$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 Supplies & 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 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 & Equipment	\$300	\$300	n/a
Accidental Death	\$4,000	n/a	n/a
Out-of-Province Referral	\$50,000/person lifetime maximum	\$50,000/person lifetime maximum	n/a
Ground 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 Prescription Drugs	\$2,000	\$1,000	\$1,000
Accidental Injury to Natural Teeth	\$5,000/injury	\$2,000/injury	\$500/injury
Wheelchairs, 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

Additional Coverage Options

Prescription Drug	Payment up to \$3,500 for formulary 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.

This is a summary of benefits. Please refer to the policy wording for complete details.

IMPORTANT NOTICE

PLEASE READ YOUR POLICY CAREFULLY

What am I covered for?

Your health insurance plan provides coverage under one of three health plan options, either OmniPlan®, ExtendaPlan® or BasicPlan, and your selection of additional coverage options. Please refer to your receipt, renewal statement or member card letter to determine which plan design and options you have purchased. Please read your policy carefully.

Am I covered for prescription drugs, dental care, hospital cash or annual travel medical?

These are optional additional coverages that must be purchased along with, and in addition to your health plan. Please refer to your receipt, renewal statement or member card letter to determine which options you have purchased. Additional coverages may be added to your plan at the time of purchase or at any subsequent annual renewal.

How do I make a health or dental claim?

An easy to complete health and dental claim form is available from your insurance broker and is also available for download and printing from the Group Medical Services website at www.gms.ca/forms. Just add your claim details and send the form and receipts to GMS by mail.

How do I make a prescription drug claim?

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

Does my plan include coverage for medical emergencies while travelling?

The additional coverage option Annual Travel Benefits includes coverage for medical emergencies while travelling outside your province of residence. Please refer to your receipt, renewal statement or member card letter to determine the specific health plan and additional options you have purchased.

Your insurance has exclusions, conditions and limitations. You should carefully read and understand your policy before you travel. Pre-existing medical conditions may be excluded from travel coverage. Any medical condition and/or symptoms you are aware of prior to the effective date, whether diagnosed or not, may not be covered. Coverage is excluded for travel to countries under Canadian government travel advisory at the time of your departure.

Does this insurance cover trip cancellation or baggage?

Your health insurance does not provide coverage for trip cancellation, interruption or baggage loss, damage or delay. Non-medical travel insurance for trip and baggage costs can be purchased separately. See www.gms.ca/travel for more information.

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

For medical emergencies and assistance, GMS is available 24-hours a day, 7 days a week by telephone. Please immediately call toll-free 1-800-459-6604 (within Canada & USA) or worldwide collect to (416) 260-4970. We will use our best efforts to provide assistance for any medical emergency.

Is my personal information private and protected?

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

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

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Policy Wording

This policy outlines the terms and conditions for the Group Medical Services (GMS) Individual Health Plan options and additional coverage options. Please refer to the appropriate sections for the health plan option and additional coverage that you have selected and submitted the required payment to GMS for.

INDIVIDUAL HEALTH PLAN BENEFITS

Included below is a listing of eligible benefits for **OmniPlan**®, **ExtendaPlan**® and **BasicPlan** options.

GOODS AND SERVICES

Goods and services purchased will be based on *reasonable and customary* charges within your province of residence. Reimbursement will not be made when gift certificates were used for the payment of goods and services.

OmniPlan®: Goods may be purchased within Canada, for use within your province of residence. Services must be provided within Canada.

ExtendaPlan®: Goods may be purchased within Canada, for use within your province of residence. Services must be provided within your province of residence.

BasicPlan: Goods may be purchased within Canada, for use within your province of residence. Services must be provided within your province of residence.

If you have submitted the required premium payment, Group Medical Services will provide payment for the following benefits:

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®	ExtendaPlan®	BasicPlan
Maximum \$75 per person in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> .	Not covered.	Not covered.

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®	ExtendaPlan®	BasicPlan
Maximum \$200 per person in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> .	Not covered.	Not covered.

3. Health Practitioners

Payment of the costs for acupuncture, chiropractic, chiropody/podiatry, clinical psychology, massage therapy, naturopath, 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 governing association(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 service within the scope of practice for each individual practitioner.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$35 per visit to a maximum of \$300 per specialty per person per <i>policy year</i> .	Maximum \$35 per visit to a maximum of \$250 combined per person per <i>policy year</i> .	Not covered.

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 is available following one (1) year of continuous membership in the plan.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$800 per person in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> . Purchase or repair.	Maximum \$500 per person in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> . Purchase only.	Not covered.

5. Health Supplies & Equipment

Payment for the purchase or rental of splints; purchase or repair of braces that contain metal or hard plastic components; 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*), aero chambers, compressors (once in the five (5) most recent *policy years*, including the current *policy year*). A *physician* must prescribe any of the above items in writing.

OmniPlan®	ExtendaPlan®	BasicPlan
Overall maximum of \$500 per person per <i>policy year</i> .	Overall maximum of \$500 per person per <i>policy year</i> .	Not covered.

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. Reimbursement for the cost of testing devices is available following one (1) full year of enrolment in the plan. This benefit excludes insulin and other prescription medications.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$300 per person per <i>policy year</i> .	Maximum \$300 per person per <i>policy year</i> .	Not covered.

7. Oxygen Equipment

Payment for the cost of oxygen equipment rental and/or CPAP supplies when ordered by a *physician* for use in the home. Reimbursement for the cost of CPAP supplies is available following one (1) full year of enrolment in plan. This benefit excludes CPAP machines and the cost of oxygen.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$500 per person per <i>policy year</i> to a lifetime maximum of \$2,500 per person.	Maximum \$500 per person per <i>policy year</i> to a lifetime maximum of \$1,500 per person.	Not covered.

8. Blood Pressure Monitors

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

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum one (1) per policy, in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .	Maximum one (1) per policy, in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> .	Not covered.

9. Custom Made Foot Orthotics

Payment of 80% for the purchase of custom made foot orthotics. The orthotic must be made by an accredited podiatric biomechanics laboratory and created using a 3-dimensional impressing technique or a 3-dimensional model of the foot and be made from raw materials. Three-dimensional impressing techniques include foam box impression, plaster casting and direct mould. This benefit excludes payment for the costs of assessment, casting or scanning.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum once per person in the three (3) most recent <i>policy years</i> , including the current <i>policy year</i> for adults, and once per person per <i>policy year</i> for children under sixteen (16) years of age.	Maximum once per person in the five (5) most recent <i>policy years</i> , including the current <i>policy year</i> for adults, and once per person per <i>policy year</i> for children under sixteen (16) years of age.	Not covered.

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 and boots or shoes with trends or fashion that have pointed toes.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$200 per person per <i>policy year</i> .	Maximum \$200 per person per <i>policy year</i> .	Not covered.

11. Mobility Aids

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

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$300 per policy per <i>policy year</i> .	Maximum \$300 per policy per <i>policy year</i> .	Not covered.

12. Ostomy Supplies

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

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$300 per person per <i>policy year</i> .	Maximum \$300 per person per <i>policy year</i> .	Not covered.

13. Accidental Death

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®	ExtendaPlan®	BasicPlan
Maximum \$4,000 per person.	Not covered.	Not covered.

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. The claim must have prior written approval from *GMS*. *GMS* will not approve payment for services where there are provincially funded *treatment* options available in *your province of residence*. Payment will not be made for any condition that existed in the twelve (12) months prior to the effective date of coverage. Referrals for services that are outside Canada are excluded from this benefit.

OmniPlan®	ExtendaPlan®	BasicPlan
Maximum \$50,000 per person per lifetime.	Maximum \$50,000 per person per lifetime.	Not covered.

15. Ambulance

Payment of *reasonable and customary* cost 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 if *you* are bedridden and returning to *your* place of permanent residence. 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, 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 *in-hospital*, 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, <i>in-hospital</i> or in home as palliative care per person per <i>policy year</i> . Nursing services in the home must commence immediately following release from <i>hospital</i> and be consistent with the <i>treatment</i> of the condition for which <i>you</i> were hospitalized.	Maximum \$2,500, <i>in-hospital</i> or in home as palliative care per person per <i>policy year</i> . Nursing services in the home must commence immediately following release from <i>hospital</i> and be consistent with the <i>treatment</i> of the condition for which <i>you</i> were hospitalized.	Maximum \$1,500, <i>in-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 be reported to *GMS* within six (6) months of the accident and coverage must be continuous from the date of injury to the date of service for this benefit to be payable. Payment for any claim is based on the date services are rendered not on the date of injury. Reimbursement of services is subject to fees provided in the *dental fee guide* for *your province of residence* in effect at the time that the services are rendered. Services totalling \$300 or more must have approval from *GMS* before the services have begun. 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 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, or a personal care home.

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*. This benefit is available following one (1) full year of enrolment in the plan.

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 mastectomy patients, or \$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 mastectomy patients, or \$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 mastectomy patients, or \$350 in the two (2) most recent <i>policy years</i> , including the current <i>policy year</i> , for bilateral mastectomy patients.

INDIVIDUAL HEALTH PLAN ADDITIONAL COVERAGE OPTIONS

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

Additional coverage options may be added to *your* OmniPlan®, ExtendaPlan® or BasicPlan option at the time of initial purchase or at *your* annual renewal.

Dental Care Benefits

If you have selected the Dental Care additional coverage option and have submitted the required payment, Group Medical Services (GMS) agrees to pay Dental Care benefits within Canada based on the *Dental Fee Guide* within *your province of residence* as follows:

- 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*.
- BASIC DENTAL SERVICES**

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

 - Complete dental examinations once per three (3) *policy years*, including the current *policy year*.
 - 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.
 - 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*.
 - Treatment* planning and consultation.
 - Diagnostic casts once per three (3) *policy years*, including the current *policy year*.
 - Scaling, to a maximum combined with periodontal root planing of ten (10) time units per *policy year*.
 - Periodontal root planing, to a maximum combined with scaling of ten (10) time units per *policy year*.
 - Polishing, two (2) time units per *policy year*.
 - Topical fluoride *treatment*, two (2) time units per *policy year*.
 - Pit and fissure sealants, once per tooth per lifetime for dependent children under eighteen (18) years of age.
 - 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.
 - Space maintainers and maintenance when a *dentist* has removed a primary tooth and an appliance is used to maintain space for a permanent tooth.
 - Interproximal diskings of teeth.
 - Occlusal adjustment and equilibration, to a maximum of four (4) time units per *policy year*.
 - Basic restorations of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations, and plastic restorations.
 - Endodontic *treatment* for permanent teeth including *treatment* of the pulp chamber, root canal therapy, 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 (including Bruxism) for the control of oral habits, 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;

- 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 are limited to teeth extracted while *you* are covered under this plan, to a maximum of one (1) per arch.
- c) Replacement of complete or partial dentures are limited to 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 provided the existing bridge pontic or fixed bridge retainer is at least five (5) years old.

DENTAL CARE LIMITATIONS

The following limitations apply to the Dental Care benefits.

1. Services totaling \$300 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 \$300 for the services performed.
2. This policy covers only necessary and adequate dental services. The excess charges of alternate courses of *treatment* over and above the charges for necessary and adequate dental service in the circumstances shall not be covered by this policy and shall be *your* responsibility. Where there is any dispute as to necessary and adequate dental services, the reasonable determination of *GMS* shall be final.

3. *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.
4. Coverage must be continuous for Dental Care benefits to be maintained. Upon cancellation, all Dental Care benefits will cease, including any pre-approved services or *treatments*.
5. *GMS* will not pay for the item classified as an "examination" in the *Dental Fee Guide* where the *dentist* performs any other separately itemized *treatment*, such as an extraction, a filling, endodontic *treatment*, periodontic *treatment* or the provision of prosthetics or the construction of crowns, in instances where a prior "examination" has determined that the separately itemized *treatment* is necessary.
6. *GMS* will cover standard cast chrome with external clasp retainers only or acrylic partial denture and where a more complicated or precision appliance is supplied, the extra cost is *your* responsibility.
7. 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 the difference in cost will be *your* responsibility.
8. Only *dentists* will be paid for x-rays.
9. 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 person became covered by this policy.
10. 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.
11. Replacement of identical restorations will only be covered once every twelve (12) months.

DENTAL CARE EXCLUSIONS

The following services or supplies are excluded from coverage under this benefit.

1. Services or supplies for injuries or conditions which are compensable under Worker's Compensation Laws.
2. Services or supplies which are provided by any Government Agency.
3. Services or supplies associated with:
 - a) *Treatment* performed for cosmetic purposes only
 - b) Congenital defects or developmental malformations or replacements of congenitally missing teeth
 - c) Temporomandibular Joint disorders.
4. Services or supplies for implantology, including tooth implantation, crowns involved in an implant procedure and surgical insertion of fabricated implants.
5. Procedure, appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or vertical wear.
6. Orthodontics.
7. Periodontal appliances, unless specified as a covered benefit.
8. Replacement of lost or stolen dentures.
9. Spare or duplicate prosthetic devices or appliances.
10. Missed appointments.
11. Completion of claim forms or pre-determinations.
12. Instruction in dental hygiene.
13. Nutritional counseling.

14. Hypnosis.
15. Prescribed drugs.
16. Experimental procedures.
17. Tissue grafts.

DENTAL CARE CONDITIONS

The following conditions apply to the Dental Care benefits.

1. Waiting Periods:
 - a) The effective date for Dental Care 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.
2. Claims:
 - a) A *GMS* claim form or a standard dental claim form must be completed and submitted when making a claim, with the following information: *your* name, *GMS* number, address and phone number, date and details of the service(s).

application for coverage and/or prescription medication for which refills were authorized at the time of application.

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 Jelly; 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 policy.
 - d) Compounds must contain an active ingredient in a therapeutic concentration that is an eligible drug under the Prescription Drug Policy.
 - 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.

PRESCRIPTION DRUG CONDITIONS

The following conditions apply to the Prescription Drug benefits.

1. Waiting Periods:
 - a) The effective date for Prescription drug coverage occurs after being enrolled in this optional benefit for thirty (30) days.
 - b) In situations where a person is changing from another *GMS* plan, waiting periods will be waived for the Prescription Drug benefits which were covered under the previous *GMS* plan and if the person was enrolled in that plan for at least thirty (30) days. The waiting period will not be waived if the previous *GMS* plan provided coverage only for *in-hospital* drugs.
 - c) In situations where a person is transferring from another insurance carrier, the thirty (30) day waiting period will be waived if the person was enrolled in that plan for at least thirty (30) days. Proof of previous coverage is required.
2. Claims:
 - a) When purchasing a prescription, provide the pharmacist with the unique identification number for the individual who is receiving the prescription. The claim will be submitted electronically for adjudication and payment.
 - b) If the *GMS* Prescription Drug Card is not used when purchasing a prescription, submit a *GMS* claim form with the original receipts attached with the following information: *your* name, *GMS* number, address and phone number, date and details of the purchase.

Prescription Drug - Enhanced Benefits

If you have selected the Prescription Drug - Enhanced additional coverage option and have submitted the required payment, Group Medical Services (*GMS*) will provide payment for the following benefits within *your province of residence*:

1. 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*,

Prescription Drug Benefits

If you have selected the Prescription Drug additional coverage option and have submitted the required payment, Group Medical Services (*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. For each eligible prescription purchased, *you* are responsible for a \$4 charge per prescription, whether submitted using *your GMS* Prescription Drug Card or by manual submission to *GMS*.

PRESCRIPTION DRUG EXCLUSIONS & 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*; drugs for which *you* have been granted *special status*; 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; patent medicines; blood and blood plasma; contraceptives and/or 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

- 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 1.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.
2. 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*.

PREScription DRUG – ENHANCED EXCLUSIONS & LIMITATIONS

The following exclusions and limitations apply to the Prescription Drug – Enhanced benefits.

1. This benefit excludes the following prescription drugs: 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; patent medicines; blood and blood plasma; 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. Generic substitutions will be used to replace brand name prescription drugs, unless “no substitutions” is specifically indicated on the prescription by the *physician*.
3. 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 Jelly; 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 policy.
 - d) Compounds must contain an active ingredient in a therapeutic concentration that is an eligible drug under the Prescription Drug policy.
 - 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.

PREScription DRUG – ENHANCED CONDITIONS

The following conditions apply to the Prescription Drug – Enhanced benefits.

1. Waiting Periods:
 - a) The effective date for Prescription Drug coverage occurs after being enrolled in this optional benefit for thirty (30) days.
 - b) In situations where a person is changing from another *GMS* plan, waiting periods will be waived for the Prescription Drug benefits which were covered under the previous *GMS* plan, if the person was enrolled in that plan for at least thirty (30) days. The waiting period will not be waived if the previous *GMS* plan provided coverage only for in-*hospital* drugs.

- c) In situations where a person is transferring from another insurance carrier, the thirty (30) day waiting period will be waived if the person was enrolled in that plan for at least thirty (30) days. Proof of previous coverage is required.
2. Claims:
 - a) When purchasing a prescription, provide the pharmacist with the unique identification number for the individual who is receiving the prescription. The claim will be submitted electronically for adjudication and payment.
 - b) If the *GMS Prescription Drug Card* is not used when purchasing a prescription, submit a *GMS* claim form with the original receipts attached with the following information: *your name, GMS number, address and phone number, date and details of the purchase.*

Hospital Cash Benefits

If *you* have selected the Hospital Cash additional coverage option and have submitted the required payment, Group Medical Services (*GMS*) will provide payment for the following benefits:

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, per diagnosis or illness. Coverage commences on the 4th day of hospitalization or on the 7th day of hospitalization due to maternity. *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.

HOSPITAL CASH LIMITATIONS

The following 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. If *you* were diagnosed with cancer in the 24 months prior to *your* application for this plan *you* will also not be covered for any cancer related *hospital* stays if they are related to *your* original diagnosis of cancer.
3. Benefits for this policy will not apply to newborn children until after they have been released from the *hospital* following birth, and, they are added to the policy and premiums paid.
4. In calculating the number of days, 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 valid when hospitalized within Canada.

HOSPITAL CASH CONDITIONS

The following conditions apply to the Hospital Cash benefits.

1. Waiting Periods:
 - a) The effective date for Hospital Cash coverage occurs after being enrolled in this optional benefit for thirty (30) days.
 - b) In situations where a person is transferring from another insurance carrier, waiting periods will be waived for the Hospital Cash benefits which were covered under the previous carrier's plan, if the person was enrolled in that plan for at least thirty (30) days. Proof of previous coverage is required in order to have benefit waiting period waived.
2. When making a Hospital Cash 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*.
3. No refunds will be provided in the event of termination of this Hospital Cash policy by the *policyholder*.

Annual Travel Benefits

If you have selected the Annual Travel additional coverage option and have submitted the required payment, Group Medical Services (GMS) will provide payment for the following benefits outside of your province of residence and Canada:

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 travel. 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.
- 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

Group Medical Services (GMS) will pay the *reasonable and customary* charges up to a maximum amount payable of \$2,000,000 of eligible expenses in the event that an unexpected medical emergency occurs outside of your province of residence or Canada.

Payment will be made in excess of any deductibles and any amounts permitted and/or paid by your provincial government plan or other insurance plans.

For expenses to be eligible, 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 option you have chosen and paid the premium for.

Eligible annual travel benefit expenses 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 thirty (30) day prescription. Drugs or medications that are lost, stolen or damaged during your covered trip are covered up to a maximum of \$50 per person. Any associated *physician's* expenses related to lost, stolen, or damaged prescriptions 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. **Road 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 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, chiropodist, 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.

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 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** – 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 up to \$2,000, with prior *GMS* approval, for returning *your vehicle*, to *your residence* or 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, 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 up to \$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 up to \$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 original point of departure. This benefit must be pre-approved by *GMS*.
21. **Coverage Continuation** – If coverage expires while hospitalized due to an *emergency*, coverage will continue for *you, your spouse* and any *dependants* travelling with *you*, up to seventy-two (72) hours after discharge from *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 that *you* are hospitalized on the 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:**
- Co-ordination of all medical care, transportation, and repatriation.
 - Telephone interpretation services in most languages.
 - Monitor progress during *treatment* and recovery by managed care.

ANNUAL TRAVEL ELIGIBILITY

- 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.
- Coverage for all medical conditions and/or symptoms that existed prior to the departure date from your province of residence are subject to the following:**
 - The following expenses are not covered by this policy and no payment for these claims will be made:
 - Your* medical condition and/or symptom(s) (whether or not a diagnosis has been determined) if at any time in the period, as specified in 2.b) below, immediately prior to *your departure date from your province of residence* your medical condition(s) or related condition(s) and/or symptoms have not been *stable*;
 - if at any time during the time period specified in 2.b) below, immediately prior to *your departure date from your province of residence*;
 - any heart condition has not been *stable*;
 - any lung condition has not been *stable*.
 - Exclusion Period

Applies to:	Time Period
All individuals, regardless of age, who: <ol style="list-style-type: none"> use home oxygen for heart and/or lung disease; have undiagnosed episodes of syncope/ fainting or falling; have kidney failure; have both <i>heart disease</i> and insulin dependent diabetes and are taking medication for both; or have congestive heart failure. The time period applies to all of <i>your</i> medical conditions including the five conditions noted above.	365 days
All other individuals, age 69 and under	90 days
All other individuals, age 70 and older	180 days

ANNUAL TRAVEL EXCLUSIONS & LIMITATIONS

The following exclusions and limitations apply to the travel benefits included with the Annual Travel additional coverage option outside of *your province of residence* and Canada:

These expenses are not covered by the policy and no payment for these claims will be made:

- Expenses incurred where *you* act against medical advice or the advice of *GMS*.
- Expenses resulting from the regular care of a chronic condition.
- Expenses incurred as a result of *non-adherence* with medical *treatment* prior to departure.
- 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.
- 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*.
- Treatment* at a diagnostic facility unless pre-approved by *GMS*.

7. *Emergency* air transportation or return to *province of residence*, which is not arranged and pre-approved by *GMS*.
8. 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.
9. Drugs and medication which are commonly available without a prescription, not legally registered or approved in Canada, experimental drugs or preventative medicines or vaccines.
10. Transplants at *your destination*, including but not limited to organ transplants, bone marrow or stem cell transplants.
11. Any services or expenses incurred when a journey 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*.
12. Expenses resulting when travel is booked or commenced contrary to medical advice.
13. Pregnancy, miscarriage, childbirth or complications of any of these conditions occurring after the first eighteen (18) weeks of pregnancy.
14. Routine or general physical examinations, check-ups or services of a continued nature following *emergency treatment* of a sickness or injury.
15. Coronary artery angioplasty, cardiac surgery or implantable cardioverter defibrillator (ICD) (including any associated diagnostic tests or charges), unless necessary in a medical *emergency* and approved by *GMS* prior to any actions.
16. Any endovascular surgical procedures, either done individually or in combination with conventional surgical procedures.
17. Any *treatment* or surgery, which is considered by *GMS* to be experimental. *GMS* opinion on the issue is final and binding.
18. *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*.
19. Any persons holding a work visa from the country to which they are traveling; or for persons working in hazardous occupations.

TRAVEL CONDITIONS

1. *You* must purchase the plan prior to *your departure date* from *your province of residence*.
2. 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.
3. 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*.
 - 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 *policy year*;
 - iii) *you* have not made travel claims during the current *policy year*;
 - iv) *you* are not anticipating any medical *treatment*;
 - v) *you* have paid the appropriate premiums;

4. 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*.
5. *GMS*, in consultation with the 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*. Refusal to do so will absolve *GMS* of further liability.
6. *GMS* is authorized to receive reports indicating diagnosis and services rendered to *you* from any *physician*, health care provider, other person, *hospital* or institution.
7. Any material misrepresentation, provision of incorrect information or non-disclosure of information, related to medical conditions, will result in non-payment of any related claims.
8. It is *your* responsibility to provide proof that the dates of travel are consistent with the terms of this policy.
9. Waiting Periods:
Travel coverage has no waiting period.
10. 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 a 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 coverage and proof of provincial health plan payment.
11. No refund will be provided on the travel benefits portion of your policy in the event of termination of this policy.
12. 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.

GENERAL CONDITIONS, EXCLUSIONS AND LIMITATIONS

The following conditions, exclusions and limitations apply to all health plan options and additional coverage options.

1. Changes to this policy may be made at any time during the *policy year* subject to the following conditions:
 - a) Changes to *your* health plan option may be made at any time during the *policy year*, subject to *GMS* approval;
 - b) Benefits not covered under *your* existing policy with *GMS* are subject to waiting periods as outlined in the policy. If the benefit was included under the previous policy, the waiting period is waived;
 - c) *You* have paid the appropriate premium amounts.
2. The Prescription Drug, Prescription Drug - Enhanced, Dental Care, Hospital Cash and Annual Travel additional coverage options can only be purchased at time of application or renewal.
3. New Individual Health Plan applicants are subject to a general thirty (30) day waiting period, from the *policy effective date*, for the health benefits within Canada. The general waiting period, excluding those with a one (1) year waiting period, will be waived if the applicant is transferring from another carrier.
4. Enrolment is open to anyone on a *single, couple or family* basis, who have valid health coverage from their *province of residence*, and who remain in their *province of residence* for a minimum of one hundred and eighty (180) days of each calendar year. This is subject to verification.
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 notice.
6. *GMS* must be notified within thirty (30) days and any appropriate premium must be paid in order to add a newborn to the policy from their date of birth. If we are not notified within thirty (30) days, or if the appropriate premium is not paid, a thirty (30) day waiting period on all benefits will apply from the date we are notified. When adding other dependants to the policy a thirty (30) day waiting period will be applied once the appropriate premiums are paid.
7. All amounts stated in this policy are in Canadian funds.
8. 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.
9. 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*.
10. 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.
11. In the event that *you* have concurrent insurance from another source(s) for benefits provided under this policy, benefits shall be coordinated 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, that 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;
 - ii) Any employment/retirement related plan; then
 - iii) Any other plan, including *GMS*. In this case, the benefits shall be pro-rated according to the maximum amounts that would have been payable as the result of the benefit contained under the respective plans. *You* agree that pro-rated sharing is what was intended when the policy was entered into and that sharing on any other basis including on the basis of independent liability and/or equal sharing is not what was intended or agreed to;
 - iv) The private plan (Individual Health Plan) where the insured person is covered as a member.
12. No benefit will be 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 support coverage programs that exist or may come to exist.
14. *GMS* is not responsible for the availability, quality or results of any medical *treatment* or transportation or *your* failure to obtain medical *treatment*.
15. Individuals failing to provide payment for the policy within one (1) month of the renewal will automatically have their policy terminated.
16. 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.
17. 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.
18. No benefit will be provided for expenses resulting from participation in professional sports, any speed contest, SCUBA diving (unless PADI, ACUC or SSI certified), 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.
19. Any material misrepresentation, provision of incorrect information or non-disclosure of information will result in non-payment of any claim and will void *your* coverage.
20. If *GMS* determines that there is no coverage for a claim(s) under this policy all amounts advanced to *you* or on *your* behalf will be repaid by *you* to *GMS* on demand. In such circumstances any payment(s) made by *GMS* will not constitute an acceptance of coverage.
21. 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* herein listed.

- b) *GMS* to collect, store and use any information which is provided or information obtained pursuant to clause (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 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).
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. The application, this policy, any document attached to this policy when issued, and any amendments to the policy 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.
25. *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*.
26. *GMS* shall, upon request, furnish to the *policyholder* or to a claimant under the policy a copy of the application.
27. No statement made by *GMS* or the *policyholder* at the time of application for this policy shall be used in defence 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.
28. Termination
- a) By the *policyholder*: The *policyholder* may terminate the policy at any time by giving written notice to *GMS*. Termination shall take effect on the later of the date of termination stated in the notice or the date that the notice is received by *GMS* at its head office. Upon termination, any unpaid portion of the annual premium is immediately due and payable, except as provided in paragraph 29 (a) following.
- b) By *GMS*: *GMS* may terminate this policy at any time by giving thirty (30) days written notice of termination to the *policyholder*. If your policy is claims free, *GMS* will refund the pro-rated portion of any premium for the remaining term of the *policy year* that has been paid in advance to *GMS*.
- c) If termination occurs within seven (7) days from receiving confirmation of coverage, you may cancel and receive a full refund.
29. Refund
- a) If the policy is terminated by the *policyholder* prior to the end of the *policy year*, and no claim has been made under the policy during the *policy year*, *GMS* will refund to the *policyholder*, the pro-rated portion of any premium received in advance.
- b) Following the date of termination, where a refund has been issued, 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.
- c) Refunds will be subject to a \$20 administration fee, no refund will be issued for any amounts under \$5.
30. Default
- a) In the event any portion of premium remains outstanding, *GMS* reserves the right to recover the full amount paid to the *policyholder*.
- b) *GMS* reserves the right to suspend claims reimbursement until such time as payment in full is received.
- c) In the event of non-payment of premiums, *GMS* reserves the right to terminate the policy.
31. Claims
- Conditions 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) All claims must be submitted within twelve (12) months of the date of service in order to be eligible for reimbursement.
- c) 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.
- d) However, if the contract has expired, any claim must be submitted to *GMS* within thirty (30) days following the expiry date.
- e) *GMS* may pay benefits under this contract to the *policyholder*, or may pay part or all of the benefit directly to the provider of the service.
32. 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.
33. Claim forms are available on-line at www.gms.ca, at the office of any *GMS* agent, or from *GMS*' head office.
34. As a condition precedent to recovery of insurance monies under this contract:
- a) the claimant shall afford to *GMS* an opportunity to examine 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, *GMS* may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.
35. 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*.
36. This policy is subject to the statutory conditions of the Insurance Act applicable to contracts of Accident and Sickness insurance in your province of residence in Canada.

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.

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

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

Couple: 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. *GMS* has adopted a *dental fee guide* for those provinces who do not have their own.

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:

- eighteen (18) years of age and under; or
- twenty-four (24) years of age and under if the child is undergoing full-time student educational training in Canada (OmniPlan®) or in *your province of residence* (ExtendaPlan® and BasicPlan)
- a developmentally or physically disabled child, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the ages indicated above to ensure continuing eligibility.

Emergency: a sudden or urgent happening requiring immediate action. A travel *emergency* no longer exists when the medical evidence indicates that no further medical *treatment* is required at destination, or indicates *you* are able to return to *your province of residence* for further *treatment*.

Family: three (3) or more people, consisting of two (2) persons living in a spousal relationship with one (1) or more *dependants* or a parent with two (2) or more *dependants*.

Formulary: those prescription drugs that a provincial government includes on their provincial drug plan *formulary* and for which they provide 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 Plans or Government Health Insurance Plan: any plan of insurance provided by or under the administrative control of any government or 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 myocardial pathology.

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 *physician* always on duty and an operating room where surgical operations are performed by a 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 home, rehabilitation centre, rest home, nursing home for the aged, 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 cooperate 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. A *physician* does not include a naturopath, herbalist, or homeopath.

Policy effective date: the date that the application is received at *GMS'* office or the office of an authorized agent. 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: the twelve (12) months following the *policy effective date*.

Province of residence: the province that *you* have declared as *your* permanent residence and 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 that service in the particular area where the service is 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 for which:

- there have been no new symptoms, more frequent or more severe symptoms;
- 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. It does not include a change from a brand name medication to a generic brand medication of the same dosage);
- there has been no deterioration of *your* medical condition;
- 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;
- there is no further testing, *treatment* or investigation booked or results pending;
- you* have not experienced a symptom that remains undiagnosed;
- no further medical *treatment* after departure would be anticipated.

Surgeon: a *physician* who is licensed to practice surgery.

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 condition, symptom or problem.

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

Welcome

Group Medical Services has been serving the health and travel insurance needs of thousands of Canadians – many of your friends and neighbours – since 1949. At GMS, we provide insurance coverage tailored to your personal needs, at an exceptional value, while making the entire application process pleasant and easy to understand.

Our health care system has undergone significant changes in recent years – so have advances in medical technology, treatment and medications. Like many of you, I wonder if our provincial health plans will provide the kind of coverage my family deserves. I'm happy to know that health coverage from GMS helps to fill in the gaps.

Our team of experts – a network of trusted insurance brokers and our friendly, knowledgeable Customer Care Centre Representatives – will provide you with personalized service, helping you select the health plan and options that are right for you. Our website, www.gms.ca, provides complete, up-to-date information – 24/7.

Thank you for considering Group Medical Services. We are truly committed to looking after you and the ones you love.

Shirley Raab
President and CEO



Questions? Comments? Family growing? Need a claim form?

Group Medical Services Customer Care Representatives are here to help. Call 1-800-667-3699 from anywhere in Canada for fast and friendly service.

Prefer email? Send a note to info@gms.ca and be sure to include your GMS Member ID number. Visit our website at www.gms.ca for current information, applications, policy information and claims forms.

For questions regarding your GMS Individual Health policy, claims, to obtain a claim form or to make changes to your personal information, please contact:

Group Medical Services

#200 – 3303 Hillside Street
Regina SK S4S 7J8

Phone: 1-800-667-3699 or (306) 352-7638

Fax: (306) 525-6360

Email: info@gms.ca

Web: www.gms.ca

If your plan includes travel coverage:

**In the case of a medical emergency or
to receive assistance, contact us
24-hours a day, 7 days a week**

Toll Free: 1-800-459-6604

(within Canada & USA)

OR

Collect: (416) 260-4970

(from all other locations)

Always call GMS travel assistance before you seek medical attention to ensure the best possible medical care and coverage of your expenses. Our assistance centre is available to help you obtain medical treatment, coordinate medical care and transportation, verify coverage and provide foreign language support.

Also available from Group Medical Services



Travel Insurance

Travel carefree with daily and multi-trip out-of-country emergency medical and non-medical coverage.

- Single Trip Daily Emergency Medical Plans
- Multi-Trip Annual Emergency Medical Plans
- Trip Cancellation & Interruption Insurance
- Baggage Loss, Damage & Delay Insurance
- Coverage for Skis, Golf, Sports and Computer Equipment
- All-Inclusive Travel Insurance Plans



Immigrants & Visitors to Canada

Emergency medical insurance for those newly arrived in or visiting Canada, including helpful assistance to coordinate treatment and care.



StudentPlan

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



Individual Health

Health plan options for people leaving employer-sponsored or group benefit plans.



Group Medical Services

#200 - 3303 Hillsdale Street, Regina SK, S4S 7J8
Toll-Free: 1-800-667-3699 Fax: (306) 525-6360
Email: info@gms.ca

www.gms.ca

Group Medical Services is the operating name for
GMS Insurance Inc. in provinces outside of Saskatchewan.

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