



My Health Coverage

EFFECTIVE MAY 6, 2026



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NOTE: Terms printed in italics have corresponding definitions available in the **Definitions** section of this policy.

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

Health Schedule of Benefits

Health Benefits	Tier 1	Tier 2	Tier 3	Limitations, Exceptions, and Other Information
Vision Care				
Eye exams	1 eye exam	1 eye exam	1 eye exam	Per 2 years No coinsurance
Prescription Eyewear (glasses, sunglasses, contact lenses, refractive laser eye surgery)	x	\$150	\$250	Per 2 years No coinsurance
Paramedical and Mental Health Practitioners				
Health Practitioners (acupuncture, massage therapy, chiropractic, physiotherapy/athletic therapist, naturopath, speech therapist, chiropody/podiatry, dietician, osteopath)	\$250 per year combined maximum	\$350 per practitioner Maximum	\$500 per practitioner Maximum	Per year No coinsurance
Mental Health Practitioners (Psychologist, social worker, psychotherapist, clinical counsellor)	\$500 per year combined maximum	\$1,000 per year combined maximum	\$1,500 per year combined maximum	Per year No coinsurance \$100 maximum per visit
Medical Equipment and Supplies				
	\$1,500 combined maximum	\$3,000 combined maximum	\$5,000 combined maximum	Per year
Private Duty Nursing	\$1,500	\$3,000	\$5,000	Per year
Orthopedic Shoes	\$50	\$150	\$250	Per year
Medical Supplies and Mobility Aids	\$150	\$300	\$500	Per year
Braces and Splints	1 per limb	1 per limb	1 per limb	Per year
Compression Stockings	1	2	4	Per year
Oxygen Equipment and CPAP Supplies	\$200	\$350	\$500	Per year
CPAP Machine	\$500	\$1,500	\$2,500	Lifetime maximum
Ostomy Supplies	\$300	\$500	\$1,000	Per year
Breast Prostheses and Surgical Bras	x	2 breast prosthesis 1 surgical bra	2 breast prosthesis 2 surgical bra	Per 2 years
Custom Made Foot Orthotics	1 pair	1 pair	1 pair	Adults: Per 3 years Children (under 16 years): Per Year
Blood Pressure Monitors	x	1	1	Per 5 years
Hearing Aids	\$200	\$500	\$800	Per 5 years
Patient Walkers	\$100	\$200	\$300	Per 5 years
Wheelchairs, Motorized Scooters and Hospital Beds	\$1,500	\$3,000	\$5,000	Lifetime maximum
Prosthetic Appliances	\$1,500	\$3,000	\$5,000	Lifetime maximum
Flash Glucose Monitors (FGM)/Continuous Glucose Monitors (CGM)	\$500	\$1,500	\$2,500	Per year
Diabetic Supplies and Equipment	\$100	\$300	\$500	Per year
Blood Glucose Monitor	1 (included in \$100 Diabetic Supplies maximum)	1 (included in \$300 Diabetic Supplies maximum)	1 (included in \$500 Diabetic Supplies maximum)	Per 5 years
Emergency Supports				
Air Ambulance	Unlimited	Unlimited	Unlimited	Unlimited
Road Ambulance	\$1,000	\$1,500	\$2,000	Per year
Hospital Semi-Private Room	15 days \$1,000	30 days \$2,000	45 days \$3,500	Per year
Accidental Injury to Natural Teeth	\$2,000	\$5,000	\$10,000	Per injury

This is a summary of benefits only. Please refer to the *Policy Wording* for complete details.

Continued on next page

My Health Coverage

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Health Schedule of Benefits -continued

Health Benefits	Tier 1	Tier 2	Tier 3
Emergency Travel Medical			
Out of Country	8 days	30 days	63 days
In Canada	183 days	183 days	183 days
Overall Maximum	\$2M	\$2M	\$2M

GMS Care Network	Limitations, Exceptions, and Other Information
Telemedicine	Unlimited
Kids and Adult Individual Counselling	5 hours covered*
Couples Counselling	5 hours covered*
Children's Mental Health Program	Included
Health Coaching	5 hours annually
Life Transitions	5 hours annually
Career Coaching	5 hours annually
Personalized Nutrition	Unlimited
Cognitive Behavioral Therapy (CBT)	Unlimited
Pharmacy Support	Unlimited
Legal Support	Unlimited
Financial Services Support	Unlimited

*Once *your* covered hours are used up, *you* can choose to continue accessing sessions at an additional cost. *You* may be able to get this reimbursed through *your* personal benefits.

Add-ons	
Hospital Cash*	\$100 per day to a maximum of \$3,000 per policy year.
Travel Days	Increase travel by 15, 30, or 48 days per trip

This is a summary of benefits only. Please refer to the *Policy Wording* for complete details.

*Subject to a waiting period

NOTE:

- Claims must be submitted within 12 months from the date of *service* and no later than 31 days after the *policy expiry date*.
- If this *policy* terminates or lapses, *insured persons* must submit any health, dental, or drug claim which arose prior to the *effective date* of termination to *GMS* within 31 days following the date of termination of this *policy*. Opened travel claims can be submitted up to 12 months from the date of notification.
- Benefits provided by this *policy* are available when deemed *medically necessary* and provided by a *physician* or licensed health care professional. *GMS* reserves the right to request a referral and/or medical *diagnosis* from *your physician*.
- *GMS* will reimburse *services* or supplies prescribed by a *nurse practitioner* in cases where applicable provincial or territorial legislation permits *nurse practitioners* to prescribe those *services* or supplies.
- Reimbursement for goods and *services* purchased will be based on *reasonable and customary* charges up to the maximum amounts set out in each benefit, subject to conditions, exclusions, and limitations. These amounts are accessible through the My *GMS* portal.
- It is the *policyholder's* responsibility to apply for all available government health programs prior to submitting claims to *GMS*. Claim submissions must include the statement of payment or denial from the corresponding government program(s).

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Policy Wording

HEALTH

A. Health Benefits

1. Vision Care

Eye Exam: Provides payment for an eye exam conducted by a qualified *physician*, optometrist, or ophthalmologist, to measure visual acuity.

Prescription eyewear: Provides payment for prescription lenses (including prescription sunglasses), frames, contact lenses, and/or refractive laser eye surgery.

Prescription eyewear can be purchased outside of Canada (including online purchases).

Expenses for non-prescription eyewear are excluded from coverage.

2. Paramedical and Mental Health Practitioners

Provides payment for the stated *services* under the schedule of benefits. All *services* must be provided by a practitioner registered with their provincial regulatory agency. In the absence of a regulatory body in the province/territory of practice, they must be a registered member of a professional association recognized by *GMS*.

Multiple *treatments* by the same practitioner on the same day will be limited to one *treatment*.

3. Emergency Supports

Ambulance: Provides payment for emergency transport by a licensed professional ambulance and for emergency transport by a licensed professional air ambulance to the nearest *hospital* equipped to provide the necessary emergency in-patient and outpatient *treatment*.

50% of the cost of road ambulance *transportation* returning the *insured person* to their place of permanent residence will be paid if the *insured person* is bedridden upon discharge from the *hospital*.

This benefit does not cover expenses when no transport to a *hospital* occurs, or for *transportation* to or from *physician's* offices, laboratories, and medical clinics.

Semi-Private Hospital Room: Reimbursement up to semi-private *hospital* room costs as stated in the schedule of benefits. *Your policy* must have been purchased and in effect prior to the *hospital* admittance date. This benefit does not cover convalescent, respite care or if *you* have been pregnant for 21 weeks or longer on *your* application date.

Accidental Injury to Natural Teeth: Payment for the *services* of a *dentist* necessitated by *accidental* injury to sound natural teeth, such as a direct blow to the mouth, but not by an object placed in the mouth.

The injury must be reported **within 6 months** of the *accident* occurring and coverage must be in place and continuous from the date of injury to the date that dental *services* are provided in order for this benefit to be payable. Payment for any claim

is based on the date *services* are rendered and not on the date of injury. All must be completed **within twelve months** of the date of injury.

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

4. Medical Equipment and Supplies

A referral from a *physician*, complete with medical condition, is required for all equipment, supplies, and *services* unless otherwise indicated.

Foot Orthotics: Provides payment for foot orthotics. Referrals can be provided by an orthopedic surgeon, an attending *physician*, pedorthist, chiropodist/podiatrist, or certified orthotist, and requires a biomechanical exam current within the last 3 years.

Orthopedic Shoes: Provides payment for the purchase of the cost of one pair of custom shoes or to modify one pair of off-the-shelf orthopedic shoes. Referrals can be provided by an orthopedic surgeon, an attending *physician*, pedorthist, chiropodist/podiatrist, or certified orthotist.

To be eligible, modifications to off-the-shelf orthopedic shoes must be completed by a pedorthist, chiropodist/podiatrist, or certified orthotist. The cost of the off-the-shelf orthopedic shoe is not covered unless supplied by the certified professional modifying the shoe.

Private Duty Nursing: Payment for private duty nursing costs in *hospital* or in *home*, when ordered in writing by a *physician*. Nursing *services* in the *home* must commence immediately following release from the *hospital* and must be consistent with the *treatment* of the condition for which the *insured person* was hospitalized.

All *services* must be rendered by a registered nurse or licensed practical nurse. The *services* provided must require the level of expertise of a nurse.

This benefit does not reimburse expenses for homemaking or companionship *services*.

Hearing Aids: Payment for repair of, or for purchase of, a new hearing aid(s) when prescribed by and/or fitted by an audiologist or as legislated in the *insured person's province/territory of residence*.

Hearing aids can be purchased outside of Canada (including online purchases).

This benefit does not reimburse expenses for hearing aid batteries or replacement ear molds.

Medical Supplies: Provides payment for the purchase of medical supplies such as:

- a. aero chambers/ nebulizers;
- b. air casts;
- c. casts;
- d. crutches;

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- e. cryo cuffs;
- f. sacroiliac corsets;
- g. trusses;
- h. shoulder immobilizers;
- i. sacroiliac corsets;
- j. cervical collars;
- k. clavicle straps;
- l. lymphedema sleeves;
- m. rib belts;
- n. wigs (1 per policy year -included in the medical supplies & mobility aids combined maximum).

Mobility Aids: Provides payment for the purchase of mobility aids such as: canes, reaching aids, raised toilet seats, grab bars, bathtub/toilet safety rails, and bathtub/transfer benches

Braces and Splints (sacroiliac corset)*: Payment for the purchase or rental of splints and braces that contain metal or hard plastic.

Compression Stockings: Payment for compression stockings with a minimum compression factor of 20-30 mmHg.

Oxygen Equipment and CPAP Supplies: Provides payment for the purchase or rental of oxygen equipment and CPAP machine supplies for personal use in the *home*.

This benefit does not cover the cost of oxygen.

Replacement masks for CPAP machines are eligible 1 every 6 months.

CPAP Machine: Provides payment for the purchase or rental of a CPAP machine for personal use in the *home* to treat moderate to severe sleep apnea.

For a CPAP machine, a completed CPAP Coverage Request form is required with the first purchase and for any and all subsequent purchases.

For CPAP supplies, a completed CPAP Coverage Request form is required with the first purchase.

CPAP Coverage Request forms can be obtained online at *GMS.ca* and the *GMS* customer portal, or by contacting a *GMS* Customer Service Representative.

Blood Pressure Monitor: Provides payment for the purchase of a blood pressure monitor for personal use in the *home*.

Ostomy Supplies: Provides payment for ostomy supplies when required for use in the *home*.

Patient Walker: Provides payment for the purchase or rental of a walker.

Diabetic Supplies and Equipment: Provides payment for the purchase of diabetic supplies and equipment, including insulin pumps and traditional testing devices, when ordered in writing by a *physician* for use in the *home*.

This benefit excludes insulin and other prescription medications.

Blood Glucose Monitors (BGM): Provides payment for the purchase of a blood glucose monitor and related testing supplies for personal use in the *home*, when ordered in writing by a *physician* to support the management of diabetes.

Flash Glucose Monitors (FGM)/Continuous Glucose Monitors Benefit (CGM): Provides coverage for FGM and CGM sensors and CGM transmitters for patients who use insulin to manage their diabetes.

Prosthetic Appliances: Provides payment for the purchase of artificial limbs, eyes, and larynx when prescribed by a *physician*.

This benefit does not cover myoelectric limbs.

Breast Prosthesis and Surgical Bras: Provides payment for the purchase of breast prosthesis and surgical bras.

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

Expenses for wheelchairs, motorized scooters, and *hospital* beds for individuals confined to, or resident in, an active *treatment hospital*, convalescent facility, nursing *home*, extended care facility, rehabilitation center, rest *home*, or personal care *home* are not eligible.

5. Individual Assistance Program and Mental Health Support GMS Care Network

The *GMS* Care Network provides *you* and *your dependants* with services designed to support *your* mental, physical, and financial wellbeing. *You* and *your dependants* have access to:

- **Mental Health Support**
Up to 5 hours of counselling per year for *you* and *your dependants* (if applicable), including *couples* therapy. Sessions are delivered securely by video or phone. Includes *children's* mental health programming and Internet-Based Cognitive Behavioural Therapy (iCBT) for mild to moderate anxiety and depression. *Services* are confidential and voluntary.
- **Virtual Medical Care & Pharmacy**
24/7/365 access to Canadian-licensed general practitioners via text, audio, or video. Receive medical advice, prescriptions, and referrals. Includes online pharmacy services with pharmacist support and free delivery of eligible medications anywhere in Canada.
- **Coaching & Advisory Services**
Access financial, legal, career, health, nutrition, and life transition support. Guidance includes budgeting, estate planning, workplace support, parenting resources, eldercare navigation, and personalized wellness coaching.

The *GMS* Care Network can be accessed anytime by calling **1-866-798-6793** or online by logging into *your* My *GMS* portal.

A.2. Health Benefit Conditions

In addition to the General Conditions section of this *policy*, the following conditions apply to the health benefits under this *policy*.

Health benefits are available only within Canada unless otherwise stated.

Goods and *services* totaling **\$500 or more** must have prior approval from *GMS* before the purchase of goods or *services* have begun. If a prior approval is not submitted before the purchase of goods or commencement of *services*, benefits otherwise payable may be limited to \$500.

GMS will pay *reasonable and customary* charges up to the maximum amounts set out in each benefit, subject to exclusions and limitations.

A.3. Health Benefit Exclusions

The following *services* or supplies are excluded from coverage:

- Expenses for cosmetic purposes;
- Expenses for diagnostic or investigative testing;
- Expenses for *services* provided by a *family member*;
- Expenses for examinations related to surgical procedures;
- Expenses for medical supplies that are spares or alternates;
- First aid supplies, diagnostic supplies or testing equipment; and
- *Services* or supplies that are not listed on the *policy*.

Duplicate or spare medical supplies and equipment are not eligible expenses unless otherwise stipulated.

Annual Travel

A. Travel Benefits

The annual travel benefit is comprised of Out of Province/Territory and Out of Country travel benefits.

Benefits	Tier 1	Tier 2	Tier 3
Emergency Travel Medical			
Out of Country	8 days	30 days	63 days
In Canada	183 days	183 days	183 days
Overall Maximum	\$2M	\$2M	\$2M
Travel Days Add-On	Increase by 15, 30, or 48 days per trip	Increase by 15, 30, or 48 days per trip	Increase by 15, 30, or 48 days per trip

Unless otherwise stated, in the event of a *medical emergency* occurring, *GMS* will pay *reasonable and customary* expenses on *your* behalf up to the maximum indicated in *your* plan.

GMS is not responsible for the availability, quality, results, or effectiveness of any medical *treatment, transportation*, or other service, nor for *your* failure to obtain medical *treatment*.

You or someone on *your* behalf must contact *GMS Travel Assistance* prior to *treatment* whenever possible. Failure to contact *GMS Travel Assistance* within twenty-four (24) hours of receiving medical *treatment* or admission to *hospital* may limit benefits otherwise payable to 70% of eligible charges to an aggregate maximum of \$50,000.

Maximums are payable per *insured person* per *policy year* unless otherwise stated.

Out of Province/Territory Travel Benefits

In addition to *your policy* health benefits provided across Canada listed in the Health section, the below benefits are available when travelling in Canada outside of *your province/territory of residence*.

Where a listed benefit indicates a maximum, the limit is applied per *insured person*, per incident to the overall maximum indicated in the *policy*.

1. Repatriation

Expenses to transport *you* by air ambulance (excluding helicopters) or regularly scheduled common carrier back to *your province/territory of residence* for further in-hospital medical *treatment*, with written recommendation from the attending *physician* confirming that *you* are fit to travel. Pre-approval by *GMS* is required.

2. Special Attendant

Expense of round-trip *transportation* for the transport of a medical attendant to accompany *you* back to *your province/territory of residence* when ordered by the attending *physician*. The attendant must not be a friend, *family member*, associate or travelling companion. Pre-approval by *GMS* is required.

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3. **Return Of Family Member**

Expenses up to \$1,000 for one-way air *transportation* to return one accompanying *family member* insured under *your policy* to *your province/territory of residence* when:

- a. *GMS* requires that you return to *your province/territory of residence* for further in-hospital *medical treatment*; or
- b. in the event of *your death*.

Pre-approval by *GMS* is required.

4. **Return & Escort of a dependent Child/Grandchild**

Expense of one-way *transportation* to return *your* dependent *children*, or grandchildren travelling with *you*, who are under the age of 18 to *your province/territory of residence* when you have been returned to *your province/territory of residence* for further in-hospital *medical treatment*. When necessary, round-trip *transportation* for an arranged escort will be provided for under this benefit. Pre-approval by *GMS* is required.

5. **Family/Friend to bedside**

Expenses to a maximum of \$3,000 for round-trip air *transportation* for a *family member* or a close friend to visit *you* if you are travelling without a *family member* on night 3 and subsequent nights of in-hospital care as a result of a *medical emergency* when ordered by the attending *physician*. Pre-approval by *GMS* is required. *GMS* will reimburse up to \$150 per day to a maximum of \$750 for the expenses incurred by the *family member* or close friend while you are hospitalized. Original receipts must be submitted to be eligible for reimbursement.

6. **In the event of Death**

Expenses up to \$2,000 for round-trip air *transportation* to provide for the return of a *family member* who is required to attend to identify *your* remains in the case of *your death* due to a *medical emergency*. *GMS* will also reimburse up to \$300 combined for meals and accommodations incurred during travel. Pre-approval by *GMS* is required.

7. **Return of Remains**

Expenses up to a maximum of \$7,000 for the preparation and transport of *your* remains to *your province/territory of residence*, or expenses up to a maximum of \$3,000 for *your* cremation or burial at the place of death, when *your death* was a result of a *medical emergency*. This benefit does not cover the cost of a headstone, burial casket, urn, or funeral *service* expenses. This benefit covers the standard shipping container and shipping costs, death certificate, and preparation of the deceased.

8. **Return of Vehicle**

Expenses up to a maximum of \$2,000 to return *your* vehicle to *your province/territory of residence*, or a vehicle rented by *you* to the nearest rental agency, when you or any travelling companions are unable to do so because you have been returned to *your province/territory of residence* for further in-hospital *medical treatment*. Reasonable and customary expenses for this benefit include the vehicle being returned by a professional agency or the following incurred by an individual other than yourself returning the vehicle on *your* behalf: fuel, meals, overnight accommodations and one-way air *transportation*. Pre-approval by *GMS* is required. Expenses will only be

reimbursed if *your* vehicle arrived at *your* destination during the coverage period of this *policy*.

9. **Return of Cat or Dog**

Expenses to a maximum of \$300 to return *your* cat or dog to *your province/territory of residence*, when you have been returned to *your province/territory of residence* for further in hospital *medical treatment*.

10. **Child Care**

Expenses to a maximum of \$500 for licensed care of dependent *children/grandchildren* or mentally or physically challenged persons who rely on *you* for assistance, if they are travelling with *you*, should you require in-care. Pre-approval by *GMS* is required.

11. **Out-of-pocket Expenses**

Expenses up to a maximum of \$1,000 incurred by a travelling companion insured under *your policy* in the event you are in hospital receiving care on *your return date*. This benefit includes coverage for up to \$150/day for accommodations, which shall form part of the \$1,000 limit. Pre-approval by *GMS* is required.

12. **Additional Expenses**

Expenses for *hospital services*, supplies, and *medical treatment* that is necessary for emergency care during hospitalization and outpatient *treatment*. This is in coordination with *your* provincial health and *your policy* health benefits.

13. **Lost Prescription Drugs**

Drugs or medications that are lost, stolen, or damaged during a *trip* during *your* coverage period are covered up to a maximum of \$50 per *insured person/per* prescription. Any *physician* expenses related to lost, stolen, or damaged drugs or medications are excluded from coverage.

Over the counter drugs are not covered, whether prescribed or not.

Out of Country Travel Benefits

Where a listed benefit indicates a maximum, the limit is applied per *insured person*, per incident to the overall maximum indicated in the *policy*.

1. **In-Hospital Care**

Expenses for ward or semi-private *hospital* rooms, *hospital services* and supplies, and *medical treatment* that is necessary for emergency care during hospitalization.

2. **Medical Services**

Expenses for *treatment* by a *physician* or surgeon, including licensed practitioners.

3. **Diagnostic Services**

Expenses for x-rays and other diagnostic tests.

Procedures such as Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT) scans, sonograms, ultrasounds, and biopsies are not covered, among others, unless pre-authorized by *GMS*.

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4. **Outpatient Medical Treatment**
Expenses for:
- out-patient medical *treatment*, and
 - one (1) follow-up visit is covered if it is deemed *medically necessary* and directly related to the covered *medical emergency*. The follow-up visit must occur within 14 days of the initial *medical consultation*. This benefit does not provide coverage for ongoing *medical treatment* necessary to treat any medical condition once the *medical emergency* has ended.
5. **Prescription Drugs**
Expenses for drugs and medication obtained on the prescription of the attending *physician* or surgeon and supplied by a licensed pharmacist, to a maximum of 31-days per prescription.
- Drugs or medications that are lost, stolen, or damaged during a *trip* during *your* coverage period are covered up to a maximum of \$50 per *insured person*/per prescription. Any *physician* expenses related to lost, stolen, or damaged drugs or medications are excluded from coverage.
- Over the counter drugs are not covered, whether prescribed or not.
6. **Private Duty Nursing**
Expenses up to a maximum of \$5,000 for private duty nursing services performed by a Registered Nurse (must be a non-*family member*) when ordered by the attending *physician* during in-*hospital* care or in lieu of in-*hospital* care. Pre-approval is required by *GMS*.
7. **Rental of Essential Medical Appliances**
Expenses for the rental or purchase of essential medical appliances (e.g., wheelchair, crutches, canes, etc.) when needed due to a *medical emergency* that occurred on the *insured person's* *trip*. The rental expense must not exceed the cost to purchase the appliances. *GMS* pre-approval is required.
8. **Emergency Dental Services**
Expenses, to a maximum of \$2,000, due to an *accidental* blow to the mouth that requires the repair or replacement of natural teeth or permanently attached artificial teeth. Expenses, to a maximum of \$250, are also covered for the *treatment* or the relief of dental pain for any dental emergency other than that caused by an *accidental* blow to the mouth.
9. **Health Practitioners**
Expenses, to a maximum of \$300 per specialty, for the *services* of an osteopath, physiotherapist, chiropractor, chiroprapist, or podiatrist.
10. **Road Ambulance**
Expenses related to the use of a licensed road ambulance in a *medical emergency* that requires immediate *transportation* to the nearest *hospital* with adequate facilities.
11. **Air Ambulance**
Expenses for the use of an air ambulance in a *medical emergency* involving life threatening circumstances where *you* require immediate transport to the nearest *hospital* with adequate facilities to treat *your medical emergency*, to a maximum of \$20,000 per *insured person* per incident. *GMS* pre-approval is required for transport by air ambulance between *hospitals*.
12. **Remote Evacuation**
Expenses for the *insured person's* evacuation to the nearest, most accessible *hospital* from a location inaccessible by road in a *medical emergency* involving life threatening circumstances, to a maximum of \$20,000 per *insured person* per incident.
13. **Repatriation**
Expenses for transporting the *insured person* by air ambulance (excluding helicopters) or regularly scheduled common carrier back to their *province/territory of residence* from outside of Canada for further in-*hospital* medical *treatment*, with written recommendation from the attending *physician* confirming that the *insured person* is fit to travel. *GMS* pre-approval is required.
14. **Special Attendant**
Expense of the round-*trip transportation* for the transport of a medical attendant to accompany the *insured person* back to their *province/territory of residence* when ordered by the attending *physician*. The attendant must not be a friend, *family member*, associate, or travelling companion. *GMS* pre-approval is required.
15. **Return of Family Member**
Expense for one-way air *transportation* to return one (1) accompanying *family member* insured as a *dependant* under the *insured person's* benefit plan to their *province/territory of residence* when:
- GMS* requires that the *insured person* returns to their *province/territory of residence* for further in-*hospital* medical *treatment*; or
 - In the event of *insured person's* death.
- This benefit is payable to the maximum of \$1,000 per *insured person* per incident and requires *GMS* pre-approval.
16. **Return & Escort of a Dependant Child/Grandchild**
Expense of one-way *transportation* to return *your dependant children*, or grandchildren, who are under the age of 18 and travelling with *you*, to *your province/territory of residence* when *you* have been returned to *your province/territory of residence* for further in-*hospital* medical *treatment*. When necessary, round-*trip transportation* for an arranged escort will be provided for under this benefit. *GMS* pre-approval is required.
17. **Family/Friend to Bedside**
Expenses, to a maximum of \$3,000, for round-*trip air transportation* for a *family member* or a close friend to visit *you* if *you* are travelling without a *family member* on night three (3) and subsequent nights of in-*hospital* care because of a *medical emergency* when ordered by the attending *physician*. *GMS* pre-approval is required.
- GMS* will reimburse up to \$150 per day to a maximum of \$750 for the expenses incurred by the *family member* or close friend while *you* are hospitalized. Original receipts must be submitted to be eligible for reimbursement.
18. **In Event of Death**
Expenses, to a maximum of \$2,000, for round-*trip air transportation* to return a *family member* required to attend to identify the *insured person's* remains in the case of their death due to a *medical emergency*.
- GMS* will also reimburse up to \$300 combined per incident for meals and accommodations incurred during travel. *GMS* pre-approval is required.

My Health Coverage

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19. Return of Remains

Expenses, to a maximum of \$7,000, for the preparation and transport of *your* remains to *your province/territory of residence*, or expenses, to a maximum of \$3,000, for *your* cremation or burial at the place of death, when *your* death was a result of a *medical emergency*.

This benefit covers the standard shipping container and shipping costs, death certificate, and preparation of the deceased.

This benefit does not cover the cost of a headstone, burial casket, urn, or funeral *service* expenses.

20. Return of Vehicle

Expenses for returning the *insured person's* vehicle to their *province/territory of residence*, or a vehicle rented by the *insured person* to the nearest rental agency, when the *insured person* or any travelling companions are unable to do so because the *insured person* has been returned to their *province/territory of residence* for further in-hospital medical treatment.

Reasonable and customary expenses for this benefit include the vehicle being returned by a professional agency or the following incurred by an individual other than the *insured person* returning the vehicle on their behalf: fuel, meals, overnight accommodations, and one-way air *transportation*. Expenses will only be reimbursed if the *insured person's* vehicle arrived at their destination during the duration of the *trip*.

This benefit maximum is \$2000 and requires *GMS* pre-approval.

21. Return of Cat or Dog

Expenses, to a maximum of \$300, to return *your* cat or dog to *your province/territory of residence*, when *you* have been returned to *your province/territory of residence* for further in-hospital medical treatment.

22. Child Care

Expenses, to a maximum of \$500, for licensed care of *dependant children/grandchildren* or mentally or physically challenged persons who rely on the *insured person* for assistance, if they are traveling with the *insured person* and should the *insured person* require in-hospital care. *GMS* pre-approval is required.

23. Out of Pocket Expenses

Expenses, to a maximum of \$1,000, incurred by a travelling companion insured under *your policy* in the event *you* are in *hospital* receiving care on *your return date*.

Coverage Begins and Ends

Out-of-country travel coverage begins the date *you* depart from Canada.

Travel coverage ends on the earliest of the following dates:

- 1) The date *you* return to *your province/territory of residence*;
- 2) The date *GMS* returns *you* to *your province/territory of residence*;
- 3) The date *GMS* ends coverage for a *medical emergency* as a result of *your* failure to comply with *GMS'* option to return *you* to *your province/territory of residence* for further medical treatment; or
- 4) The date *you* reach the maximum *trip* length allowable under the plan option chosen.

Out-of-Canada travel coverage requires *you* to return to Canada when *you* reach the maximum *trip* length allowable under the plan before benefit coverage will be provided for subsequent *trips*.

You must maintain valid government health insurance for coverage to be valid. To do this *you* must ensure that *you* are not outside *your province/territory of residence* for more than the number of days allowable under *your government health plan* in *your province/territory of residence*.

Additional Travel Days Extension

If *you* require additional travel days after departure from Canada *you* may purchase top-up coverage through *GMS TravelStar®* Travel Insurance, provided that *you*:

- 1) notify *GMS* prior to the *expiry date* of *your policy*; and
- 2) have not incurred a claim or required medical *treatment* during *your trip*.

Automatic Extensions

Your travel plan will automatically be extended up to 72 hours if the return to *your province/territory of residence* is delayed beyond the travel coverage end date due to any of the following:

- 1) *You* are delayed due to *you* or *your* travelling companion's *medical emergency*. Written confirmation from the attending *physician* is required to verify that *you* are medically unfit to travel.

The 72-hour extension will begin once *you* have been deemed medically fit to travel or discharged from the *hospital*. In-hospital care during the *medical emergency* continues to be covered by *your policy* until *your* discharge from *hospital*;

- 1) A delay of a common carrier *you* are travelling on causes *you* to miss *your return date* to *your province/territory of residence*; or
- 2) The vehicle *you* are travelling in:
 - a. Is involved in an *accident*;
 - b. Has a mechanical breakdown; or
 - c. Is delayed by a police-directed road closure.

Policy Changes Applicable to Travel Benefits

At time of original purchase or on renewal of *your policy*, *you* may be able to *add-on* travel days to increase *your* multi-trip maximum by 15, 30, or 48 days, subject to meeting eligibility requirements and payment of applicable additional premiums.

My Health Coverage

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B. Travel Benefit Conditions

In addition to the General Conditions section of this *policy*, the following conditions apply to the out-of-country travel benefits under this *policy*: unless otherwise stated

1. Contact GMS

You or someone on your behalf must contact GMS Travel Assistance prior to *treatment* whenever possible. Failure to contact GMS Travel Assistance within twenty-four (24) hours of receiving medical *treatment* or admission to *hospital* may limit benefits otherwise payable to 70% of eligible charges to an aggregate maximum of \$50,000.

2. Restricted Travel

Notwithstanding any other provision of this *policy*, individuals who are 80 years and older as of the *effective date* of this *policy* are not covered for travel outside of Canada under this *policy*.

3. Interest Charges

Benefits payable shall not include interest charges.

4. Medical Services Required During Travel

Medical *services* required during travel must be provided when you are outside of Canada. This does not apply to travel in Canada outside of your *province/territory of residence*. Medical *services* obtained in Canada will be assessed under the health benefit of this *policy*.

5. Medical Supplies Required During Travel

Goods purchased under this travel benefit can only be purchased when you are outside of Canada. This does not apply to travel in Canada outside of your *province/territory of residence*. Medical supplies purchased in Canada will be assessed under the health benefit of this *policy*.

6. Travel Benefit Effective Date

The travel *benefit effective date* must be prior to your departure date from your *province/territory of residence* to provide coverage. This includes additional travel days *add-on* purchases.

7. Changes in Health

Should any changes to your health occur after the application date and prior to issuance of this *policy*, GMS must be notified, and your application updated. Changes to health constitute a change in stability and may limit your available coverage.

8. Medical Transfer

GMS, in consultation with the attending *physician*, reserves the right to transfer you to another *hospital* or medical facility or to return you to your *province/territory of residence* if deemed *medically necessary*.

9. Coverage Limits

Insurance is in effect only for coverage indicated on your application for which the premium has been paid. Benefits are payable in accordance with the benefits listed in this *policy* and where applicable limited to the *sum insured* as indicated.

10. Service Providers

GMS reserves the right to negotiate amounts payable on your behalf with any *service provider* who provides *services* covered by this insurance. Payments will be provided directly to the *service provider*. You may not claim or receive more than 100% of covered incurred expenses. Payment under this condition is subject to all other *policy* conditions and limitations.

11. Right to Investigate

GMS reserves the right to investigate or obtain a private opinion on any claim, and to obtain any and all information relating to a claim.

C. Travel Benefit Exclusions

In addition to the General Exclusions and Limitations section of this *policy*, the following exclusions apply to the out-of-country travel benefits under this *policy*:

1. Pre-Existing Medical Conditions

GMS does not cover any expenses resulting directly or indirectly from medical condition(s) which have not been *stable* immediately prior to your departure date for:

- a. 90 days for all individuals who were 69 years of age and younger as of the *effective date* of this *policy*;
- b. 180 days for all individuals who were age 70 and older as of the *effective date* of this *policy*; or
- c. 365 days, regardless of age, for individuals who:
 - i. Use *home oxygen* for lung and/or heart disease which includes but is not limited to angina, irregular heartbeat, heart attack, ischemic heart disease, valvular heart disease, and cardiomyopathy;
 - ii. Have undiagnosed episodes of fainting or falling syncope;
 - iii. Suffer from kidney/liver failure and/or Chronic Kidney Disease (CKD)/liver disease;
 - iv. Require insulin to treat diabetes and take *prescription drugs* for heart disease (as defined in i. above); and/or
 - v. Have congestive heart failure (CHF).

Medical conditions include:

- a. Medical condition(s) for which you received medical *treatment* or *medical consultation*; and/or
- b. Undiagnosed medical condition(s) related to symptoms for which you received medical *treatment* or *medical consultation*.

You must be *stable* based on the definition of *stable* in this *policy*, regardless of the opinion of your *physician* or any other person who may provide an opinion on your medical condition(s).

2. Recurrence of a Medical Condition

GMS does not cover any expenses for *medical consultation*, *medical treatment*, or in-*hospital* care resulting from the continuation, recurrence, or complication of an emergency medical condition, after such time that the emergency has been deemed to have ended as advised by GMS.

3. Non-Emergency Treatment

GMS does not cover any expenses resulting from medical *treatment* that is not a *medical emergency*, including but not limited to: routine or general physical exams; regular care of chronic conditions; elective surgery; dental or cosmetic surgery, even if recommended by a *physician*; and follow-ups or continued *services* following emergency medical *treatment* when not authorized by GMS.

4. Travel for Diagnosis or Treatment

GMS does not cover any expenses resulting from and/or incurred during *trips* undertaken for the purpose of receiving a *diagnosis* or medical *treatment* for travel out of province/territory and out of Canada.

5. **Delayable Treatment**

GMS does not cover any expenses for medical *treatment* that can be reasonably delayed until *you* return to *your province/territory of residence*.

6. **Transplants**

GMS does not cover any expenses for transplants, including but not limited to: organ transplants, or bone marrow or stem cell transplants.

7. **Refusal of Transfer**

GMS does not cover any expenses following *your* refusal to transfer to another *hospital* or medical facility capable of providing necessary medical *treatment*, or *your* refusal to return to *your province/territory of residence* when deemed *medically necessary*. Refusal to comply with a transfer request or a request to return to *your province/territory of residence*, when *you* could have been returned to *your province/territory of residence* without endangering *your* life or health, even if the *treatment* available in *your province/territory of residence* could be of lesser quality than the *treatment* available outside *your province/territory of residence* or *you* must go on a waiting list for that *treatment*, will void coverage under this contract from that time forward and will absolve GMS of any further liability, whether that liability is related to the initial incident or not.

8. **Refusal to Follow Medical Advice or Advice of GMS**

GMS does not cover any expenses incurred as a result of *your* refusal to follow medical advice or the advice of GMS.

9. **Non-Adherence**

GMS does not cover any expenses that result from *your* failure, prior to departure, to:

- a. Adhere to medical *treatment*;
- b. Obtain investigative or diagnostic tests recommended by a medical professional; and/or
- c. Receive results from investigative or diagnostic tests.

10. **Acting Against Physician's Advice**

GMS does not cover any expenses when *you* travel against the advice of a *physician*.

11. **Certain Pregnancy Related Matters**

GMS does not cover any expenses related to pregnancy, miscarriage, childbirth, or complications of any of these conditions occurring after the first 9 weeks of pregnancy.

12. **Certain Cardiac Procedures and Devices**

GMS does not cover any expenses for cardiac catheterization, angioplasty or cardiovascular surgery, or insertion of an implantable cardioverter defibrillator (ICD) or pacemaker, including all associated diagnostic expenses, unless necessary in a *medical emergency* and pre-approved by GMS.

13. **Non-Common Carrier Air Travel**

GMS does not cover any expenses resulting from air travel unless riding as a passenger on a common carrier.

14. **Work**

GMS does not cover any expenses for work-related *accidents*.

15. **Risky Work or Volunteer Activities**

GMS does not cover any expenses resulting from *your service* in the armed forces, willful exposure to peril, work within a hazardous occupation, or mission and/or relief work.

16. **Travel Advisory**

GMS does not cover expenses arising where, before *your* departure date, an official travel advisory is issued by the Canadian government, stating to “avoid non-essential travel” or “avoid all travel” for the country, region, city, or other destination (including cruise ships) that are part of *your* travel arrangements.

To view travel advisories, visit the Government of Canada travel site at travel.gc.ca/travelling/advisories.

17. **Failure to Obtain GMS Pre-Approval**

GMS does not cover any expenses where pre-approval by GMS is required and not obtained.

18. **Pre-Existing Nuclear Issues**

GMS does not cover any expenses resulting from any nuclear reaction, radiation, or radioactive contamination or occurrence, where the risk of exposure was present prior to *your* departure, however caused.

19. **Experimental Treatment**

GMS does not cover any expenses for any medical *treatment* considered by GMS to be experimental. GMS' opinion is final and binding.

20. **Drugs and Alcohol**

No coverage or reimbursement for:

- a. Expenses for any medical condition, including symptoms of withdrawal arising from, or in any way related to *your* use of alcohol, drugs, or other intoxicants (including cannabis) whether prior to or during *your trip*; and
- b. Out-of-pocket expenses arising from or in any way related to alcohol, drugs, or other intoxicants (including cannabis).

D. Managing a Travel Medical Emergency

In the event of a *medical emergency*:

1. *You* must contact GMS Travel Assistance, where possible, prior to seeking medical *treatment*. GMS Travel Assistance will:
 - a. Offer telephone interpretation services in many languages;
 - b. Monitor progress during *your medical consultation* and medical *treatment*; and
 - c. Coordinate all medical *treatment*, transport, and repatriation.

Contact GMS Travel Assistance toll free at 1-800-459-6604 (Canada/USA), collect at +1-905-762-5196 (WhatsApp Accessible).

If *you're* outside Canada/USA, make sure to use the call out code for the country *you're* in before dialing the collect number.

2. *You* are required to contact GMS Travel Assistance within 24 hours of receiving medical *treatment* or admission to *hospital*. Failure to do so may limit benefits to the lesser of 70% of *reasonable and customary* expenses or \$50,000.

My Health Coverage

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Contacting *GMS Travel Assistance* with a *medical emergency* constitutes a claim regardless of whether payment is made by *GMS* for any related expenses.

E. Making a Travel Claim

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

1. Original itemized receipts, bills and invoices;
2. Proof of payment, if payment was made, by *you* or any other benefit plan;
3. Complete medical records, including final *diagnosis* by the attending *physician*;
4. Proof of travel showing the date *you* departed from and returned to *your province/territory of residence*;
5. *Your* historical medical records, as requested by *GMS*;
6. Any other relevant documentation that may be requested by *GMS* as required to process a claim in the opinion of *GMS*; and
7. In the case of claims involving *your* death, *GMS* may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

Costs of obtaining documents or reports to support *your* claim are not covered.

PRESCRIPTION DRUGS

Prescription Drug Benefits

A. Drug Schedule of Benefits

Prescription Drugs				
\$6 per prescription deductible (No annual deductible), no coinsurance, no waiting period, no dispensing fee cap				
Drugs Benefits	Tier 1	Tier 2	Tier 3	Tier 4
Basic Non Pre-Existing Condition(s)	\$300	\$1,000	\$3,500	\$6,000
Enhanced Pre-Existing Condition(s)	x	x	\$800	\$1,000

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

Payment is for the expense of *eligible drugs* prescribed in writing by a physician. Coverage applies to *eligible drugs* in accordance with the applicable tier, benefit maximums, and policy terms. For Tiers 3 and 4, coverage may also include certain expenses for pre-existing conditions and certain drugs that would otherwise be ineligible, as outlined in the Schedule of Benefits and policy wording.

If brand name *prescription drugs* are dispensed, payment will be made up to the lowest cost alternative. *GMS* will only provide payment for the cost of the brand name *prescription drug* if the lowest cost alternative is not available when the drug is dispensed.

Prescription drug benefits are available in Canada.

NOTE:

- Subject to exclusions set out in this section and the General Exclusions and Limitations section of this *policy*, *prescription drugs*, including hormonal contraceptives, prescribed in writing by a *physician* will be covered based on the *formulary* in *your policy*.
- For each eligible *prescription drug*, *you* are responsible to pay a \$6 deductible, whether submitted using *your* *GMS* pay-direct card or by manual submission to *GMS*.

Per *insured person*, per *policy year*, the following amounts may be applicable:

- Tier 3: Up to \$800, included within the \$3,500 *prescription drug* coverage limit
- Tier 4: Up to \$1,000, included within the \$6,000 *prescription drug* coverage limit

These amounts may be used to purchase the following:

- *Prescription drugs* for *treatment* of pre-existing medical condition(s) including *prescription drugs* for which refills were authorized at the time *you* applied for *GMS* coverage;
- *Prescription drugs* not listed under the drug *formulary* for the *policy*;
- *Special status prescription drugs* or drugs that require prior authorization; and
- *Prescription drugs* otherwise not eligible under the **\$3,500** (Tier 3), **\$6,000** (Tier 4) limit, including but not limited to injectable vitamins, vaccines, and lifestyle drugs.

My Health Coverage

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Drugs and costs not covered by the **\$800** (Tier 3), **\$1,000** (Tier 4), per insured person, per policy year limit include:

- Drugs available without a prescription;
- Self-prescribed drugs or those drugs prescribed by a *family member*; and
- Delivery and *transportation* costs associated with the acquisition of the drug(s).

B. Prescription Drug Benefit Conditions

In addition to the General Conditions, the following conditions apply to *Prescription Drug* benefits under this *policy*:

1. **Generic Pricing:** If a brand name *prescription drug* is dispensed, payment will be made up to the cost of the generic substitution. *GMS* will provide payment for the cost of the brand name *prescription drug* if the prescribing physician indicates no substitution, or if the lowest cost alternative is not available when the drug is dispensed.
2. **Compound Drugs:** Compound drugs must contain an active ingredient in a therapeutic concentration that is an eligible drug under the *prescription drug* benefits and cannot contain an ineligible ingredient as identified by the pharmacy benefits manager.
3. **Pre-approval:** Under certain circumstances *prescription drugs* require pre-approval by *GMS*.

GMS reserves the right to determine which drugs, whether new to the marketplace or existing, will be eligible for reimbursement under the *Prescription Drug* benefit.

C. Prescription Drug Benefit Exclusions

In addition to the General Exclusions and Limitations section, the following exclusions apply to *Prescription Drug* benefits under this *policy*:

GMS does not cover expenses for drugs and medication which are commonly available without a prescription, not legally registered or approved in Canada, experimental drugs, or preventative medicines or vaccines.

GMS does not cover expenses associated with:

- Drugs which were prescribed and/or taken for the *treatment* of a medical condition prior to applying for *GMS* coverage;
- Drugs not listed on the *formulary* covered on the *policy*;
- Drugs available without a prescription;
- *Special status* drugs or drugs that require prior authorization;
- Drugs intended for the *treatment* of sexual dysfunction;
- Drugs for *treatment* of hair loss or to restore hair growth;
- Experimental drugs;
- Drugs used for the purpose of weight loss;
- Drugs used for cosmetic purposes;
- Vaccines;
- Smoking cessation drugs;
- Self-prescribed drugs or those drugs prescribed by a *family member*;
- Fertility drugs;
- Non-hormonal contraceptives;
- Vitamins; and
- Delivery and *transportation* costs associated with the acquisition of the drug(s).

If you have elected coverage that includes enhanced drug coverage, some of these exclusions may be eligible under the enhanced maximum.

The enhanced drug portion of *your* drug maximum may be used to purchase:

- *Prescription drugs* for *treatment* of pre-existing medical condition(s), including *prescription drugs* for which refills were authorized at the time you applied for *GMS* coverage;
- *Prescription drugs* not listed under the drug *formulary* for the *policy*;
- *Special status prescription drugs* or drugs that require prior authorization; and
- *Prescription drugs* otherwise not eligible under the \$3,500, drug maximum, including but not limited to: injectable vitamins, vaccines, and lifestyle drugs.

Drugs and costs not covered by the enhanced drug portion of *your* drug maximum include:

1. Drugs available without a prescription;
2. Self-prescribed drugs or those drugs prescribed by a *family member*; and
3. Delivery and *transportation* costs associated with the acquisition of the drug(s).

DENTAL

Dental Benefits

A. Dental Schedule of Benefits

Dental					
Dental Benefits No annual deductible	Tier 1 Basic only	Tier 2 Basic + Major	Tier 3 Basic + Major	Tier 4 Basic + Major	Limitations, Exceptions, & Other Information
Annual Maximum	Year 1: \$500 Year 2: \$500 Year 3: \$500	Year 1: \$500 Year 2: \$750 Year 3: \$1,000	Year 1: \$600 Year 2: \$850 Year 3: \$1,500	Year 1: \$750 Year 2: \$1,000 Year 3: \$2,000	3 month waiting period
Basic Coinsurance	50%	80%	80%	100%	3 month waiting period
Major Coinsurance	x	50%	50%	60%	12 month waiting period
Orthodontics (Dependent children under 18)	x	x	x	50%	\$2,500 Lifetime maximum 2 year waiting period

All Dental Benefits are available across Canada.

NOTE:

- GMS will pay *reasonable and customary* charges up to the maximum provided as shown in the chart above and subject to individual benefit dollar and *service* limits for *services* performed by a licensed *dentist*, *denturist*, or dental hygienist while *you* are covered by this plan.
- Maximums and procedure frequencies as per *insured person per policy year* unless otherwise stipulated.
- Regardless of the limits outlined below, GMS will not pay charges exceeding the current *dental fee guide in your province/territory of residence*.

Basic dental benefits start **three (3)** months after the *effective date* of the *policy*.

Major dental benefits start **twelve (12)** months after the *effective date* of the *policy* (Tiers 2, 3 & 4 only).

The following dental procedures are considered eligible expenses:

B. Basic Dental Services

1. Examination and Diagnostic

- Complete exam once every three (3) *policy years*
- Recall exams to a maximum of two (2) exams per *policy year*
- Specific exams to a maximum of two (2) exams per *policy year*
- Unlimited emergency exams
- One (1) of either a panoramic x-ray or complete series of x-rays every three (3) *policy years*
- Intra-oral x-rays to a maximum of 10 films every two (2) *policy years*
- Diagnostic casts -once every three (3) *policy years*

2. Preventative

- Scaling and root planing to a maximum of ten (10) *units* combined per *policy year*.
- Polishing: 2 *unit* per *policy year*.
- Fluoride: 2 *unit* per *policy year*.
- Pit and fissure sealants: once per tooth per lifetime for *dependant children* under the age of 12.
- Appliances for the control of oral habits: once per *policy year* for *dependant children* under 16 years of age and once per three (3) *policy years* for *insured persons* 16 and older.
- Appliances associated with obstructive sleep apnea, snoring, or upper airway resistance syndrome (UARS) are excluded from this benefit.
- Space maintainers and maintenance: included when a *dentist* removes a primary tooth and an appliance is used to maintain space for a permanent tooth.
- Occlusal adjustment and equilibration: 4 *units* per *policy year*.

3. Minor Restorative

- Fillings including amalgam restorations, prefabricated restorations, and composite restorations.
- Caries, trauma, pain control, and pulp capping.
- Pins.

4. Endodontic

For permanent teeth including *treatment* of the pulp chamber, root canal therapy, and miscellaneous endodontic procedures (open and drain and non-vital bleaching).

- Root canal therapy is limited to one (1) per tooth every five (5) *policy years*
- Endodontic re-*treatment* of a previous root canal is limited to one (1) per tooth every five (5) *policy years*.

5. Periodontal

- Management of oral disease and desensitization.
- Surgical *services* related to gingival curettage, gingivoplasty, gingivectomy, and flap approach: each type of *service* is limited to one (1) per site (sextant) per *policy year*.

6. Removable Prosthodontics

- Denture reline and rebasing: once every three (3) *policy years*.

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7. Basic Oral Surgery/Extractions

- Provides payment for erupted tooth extractions, surgical extractions, surgical excisions, surgical incisions, post-surgical care, and anesthesia.

8. Adjunctive Services

- Interproximal diskings of teeth.
- Emergency *treatment* of pain.
- Anesthesia: covers the cost of anesthesia when the submitted procedure is an eligible expense.
 - Charges for facility fees and fees of a separate provider to administer anesthesia are not eligible expenses.
- Laboratory fees: payment for the cost of laboratory fees when the submitted procedure is an eligible expense.
 - Eligible expenses are limited to 60% of the eligible procedure cost in the applicable *dental fee guide*.
 - Laboratory fees will be paid at the co-insurance associated with the dental procedure.

Anesthesia and laboratory fees are eligible when the associated *treatment* is an eligible expense.

Reimbursement for anesthesia and laboratory fees are limited to the reimbursement percentage of the *services* they were performed with.

C. Major Dental Services

1. Inlays, Onlays, Crowns and Veneers

- Payment for the initial placement of inlays, onlays, crowns, and veneers when the tooth has extensive structural damage due to traumatic injury or fracture of the tooth or cusps, or where significant areas of previous fillings and decay prevent the use of traditional filling materials to adequately restore the tooth.
 - If *GMS* determines there is insufficient damage to the tooth, *GMS* reserves the right to limit the reimbursement to the cost of a filling
- Replacement appliances: one (1) every five (5) *policy years*.
- Posts and cores: one (1) every five (5) *policy years*.

2. Dentures – Removable Prosthodontics

- Initial complete or partial dentures when at least one tooth being replaced was extracted while *you* are covered under this plan
- Replacement or complete partial dentures when additional teeth are extracted while *you* are covered under this plan, or if the existing appliance is at least five (5): years old
- Denture adjustments once per *policy year*
- Denture repairs
- Tissue conditioning
- Miscellaneous denture *services*

3. Bridges – Fixed Prosthodontics

- Initial bridge pontics and fixed bridge retainers when at least one tooth being replaced was extracted while *you* are covered under this *policy*.
 - If there are three (3) or more teeth missing in the arch, *GMS* will pay up to the cost of a standard partial denture only
- Replacement bridge pontics and fixed bridge retainers once every five (5) *policy years*
- Bridge repairs
- Removal of existing bridge, reinsertion and re-cementation

4. Implants

Implant-specific *services* are not eligible for coverage; however, the cost of implant-supported appliances may be eligible for consideration under the Alternate Benefit Clause.

- The Alternate Benefit Clause will apply if the tooth being replaced by an implant was extracted while *you* were covered under this *policy* or if it is replacing a previously placed appliance such as a denture or bridge.
- If approved, the initial placement of an implant supported appliance will be limited to:
 - Bridge - If fewer than 3 teeth are missing in the arch.
 - Partial denture – If more than 3 teeth are missing in the arch.
- Replacement of crowns, bridges, and dentures supported by an implant will be provided when the appliance is at least 10 years old.

D. Orthodontics (Tier 4 Only)

- Payments including provision of *services* and appliances for the correction of malocclusion including diagnostic procedures, formal *treatment*, and retention.
 - Eligible for *dependant children* if under the age of 18 when *treatment* begins
 - An orthodontic *treatment* plan must be submitted to and approved by *GMS* prior to payment being eligible
 - Lump sum payments are not eligible. If the *treatment* plan is paid in full, reimbursement will be limited to the initial fee and the balance in equal monthly installments.
 - If *you* enroll directly in Tier 4, Orthodontic dental benefits are subject to a two (2)-year waiting period. If *you* upgrade to Tier 4 from Tier 1, 2, or 3, a one (1)-year waiting period applies, regardless of how long *you* were in *your* previous tier.

E. Dental Benefit Conditions

In addition to the General Conditions section of this *policy*, the following conditions apply to dental benefits under this *policy*:

1. **Pre-Approval:** *Services* totaling \$500 or more must have prior approval from *GMS* before the *services* begin. If a dental pre-authorization is not submitted prior to commencement of *services*, benefits otherwise payable, shall be limited to \$500 for the *services* performed.
2. **Dental Fee Guide:** *GMS* will pay for *services* and procedures only to the maximum amounts as provided for in the current *dental fee guide* in *your province/territory of residence*. Any charges over and above the current *dental fee guide* will be *your* responsibility.
3. **Alternative Benefits Clause:** Payment by *GMS* will be limited to the most cost-effective *treatment* within acceptable dental standards. Should *you* and *your dentist* choose a more expensive *treatment*, *you* are responsible for any additional charges beyond the allowance for the alternative *service*. Where there is a dispute as to the most cost-effective *treatment* within dental standards, the determination of *GMS* shall be final.
4. **Prior Extraction Clause:** *GMS* will not reimburse for any dental *treatment* to replace a tooth that was extracted or missing prior to coverage.
5. **Prosthetic Devices:** Provision of prosthetic devices including complete dentures, partial dentures, fixed bridgework (and crowns that are part of the bridgework) shall not be covered under this *policy* if the device was ordered or the *service* for the device was started before the *benefit effective date*.

6. **Necessary and Adequate:** The *policy* covers only necessary and adequate dental *services*. Where there is a dispute as to necessary and adequate dental *services*, the determination of *GMS* shall be final.
7. **Transitional Appliances:** *GMS* will pay for the *services* required for a permanent appliance, deducting any amount paid for a temporary appliance when making the transition within one year of *services* commencing.
8. **Multiple Restorations:** Multiple restorations submitted on the same tooth within 12 months will be limited according to *reasonable and customary* charges as indicated in the current *dental fee guide*. Replacement of identical restorations will only be covered once every 12 months.
9. **Continuous Coverage:** Coverage must be continuous for benefits to be maintained. Upon termination, all benefits will cease, including any pre-approved *services* or *treatments*.

F. Dental Benefit Exclusions

In addition to the General Exclusions and Limitations section of this *policy*, the following exclusions and limitations apply to dental benefits under this *policy*:

GMS does not cover expenses associated with:

- Dental *services* principally for cosmetic purposes;
- Congenital defects or developmental malformations;
- *Services* associated with temporomandibular joint disorders;
- Expenses for implants, implant-related *services* or crowns involved in an implant procedure and surgical insertion;
- Tissue grafts, bone grafts, Oral Hygiene Instruction and CBCt 3D scans;
- Note: this is not an exhaustive list; it is recommended to submit an estimate to verify eligible procedures prior to having any work done;
- Replacement of lost, stolen, or misplaced appliances;
- Cancellation fees for appointments otherwise not kept;
- Expenses incurred to increase vertical dimension and repair or restore teeth damaged or worn due to attrition or vertical wear;
- Crowns placed on teeth that are not functionally impaired by incisal or cuspid damage;
- Expenses incurred under any of the conditions specified in the General Exclusions and Limitations section of this *policy*;
- Experimental *treatment*; and
- *Service* or supplies rendered outside of Canada.

ADDITIONAL COVERAGE

Hospital Cash (Add-on)

This coverage is only available if you have purchased the *Hospital Cash* additional coverage option at the time of application or at renewal. *Hospital Cash* cannot be added mid-term during the *policy* year.

A. Hospital Cash Benefit

When you are confined to a *hospital* and undergoing active *treatment* on an in-patient basis due to an *accident* or illness, this benefit provides payment per *insured person* admitted to *hospital* of \$100 per day, up to a maximum of \$3,000 per *policy* year.

GMS will provide payment on specific dates based on the reason for hospitalization:

- For illness or injury, *GMS* will pay on the **4th day**; and
- For pregnancy, childbirth, or pregnancy-related medical conditions, *GMS* will pay on the **7th day**.

B. Hospital Cash Exclusions

The following exclusions apply to the *Hospital Cash* benefit:

1. **Benefit Restrictions**
Hospital Cash expenses are not payable if, on the application date, you were:
 - a. Hospitalized; or
 - b. Awaiting or scheduled for in-*hospital* care or surgery.
2. **Cancer**
Hospital Cash expenses are not payable for cancer-related *hospital* stays if you were diagnosed with cancer prior to the application date.
3. **Pregnancy**
The following pregnancy-related circumstances will impact your *Hospital Cash* benefits:
 - a. *Hospital Cash* expenses resulting from pregnancy or complications due to pregnancy are not payable if, on your application date, you have been pregnant for 21 weeks or longer; or
 - b. If you were fewer than 21 weeks pregnant on the application date, payment under this benefit will be limited to two (2) days of *Hospital Cash* following six (6) days of continuous hospitalization because of pregnancy or complications due to pregnancy.

C. Hospital Cash Conditions

The following *Hospital Cash* conditions are in addition to the General Conditions of this *policy*.

1. **Benefit Calculation**
When calculating the number of days for coverage, date of admission and date of discharge are counted as one day each.
2. **In Canada Only**
The *Hospital Cash* benefit is only payable when you are hospitalized within Canada.
3. **Newborn Children**
Newborn *children* are not eligible for *Hospital Cash* benefits

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until they have been released from the *hospital* following birth, they are added to the *policy*, and the appropriate premiums are paid.

D. Hospital Cash Benefit Claims

Hospital Cash is only payable with the submission of a *Hospital Cash Claim Form* and official *hospital* discharge papers including both the admission and discharge dates to *GMS's* headquarters in Regina, Saskatchewan.

Additional Travel Days (Add-on)

At time of original purchase or on renewal of *your policy*, you may be able to *add-on* travel days to increase *your multi-trip* maximum by 15, 30, or 48 days, subject to meeting eligibility requirements and payment of applicable additional premiums. These *add-on* travel days apply for one *policy year* only and do not automatically renew.

Add-on travel days increase the maximum number of consecutive days you are covered per *trip* and apply to each separate *trip* taken during the *policy year*, provided you return to *your province of residence* between *trips*. Coverage resets for each new *trip*, up to the applicable maximum number of days. *Add-on* travel days must be purchased for all covered *dependants* under the *policy* and cannot be carried forward to future *policy years*.

All other terms, conditions, limitations, and exclusions of the Travel Benefit continue to apply.

HOW TO MAKE A CLAIM

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

For travel reimbursement refer to "D. Managing a Travel *Medical Emergency*" on page 11 and "E. Making a Travel Claim", on page 12.

To make a *Hospital Cash* claim refer to section "D. *Hospital Cash Benefit Claims*" on page 16.

- 1. Self-service online** – To make things quick, convenient and easy, register for a My *GMS* portal at www.gms.ca to: submit *your* claims online and attach copies of *your* receipts;
 - sign up to have *your* claim payments directly deposited into *your* bank account;
 - view and print *your* personal claim statements;
 - access *your* *GMS* ID numbers;
 - access a copy of this contract;
 - find eligible health care *service* providers near *you*; and
 - access *GMS* Care Network.
- 2. Provider submit** – To avoid paying out of pocket, present *your* pay-direct card for *prescription drugs* at the pharmacy and at *your dentist* for all dental *services*. For other health care provider claims, check our provider search tool at www.gms.ca/provider-locator to help *you* locate vision care providers, chiropractors, massage therapists and physiotherapists near *you*.
- 3. Other options** – claim forms are available for download at <https://www.gms.ca/health-dental-claims>. Complete the form, attach *your* itemized receipts and mail to *GMS* head office in Regina. For submitting *your* dental claim manually, *GMS* requires a Standard Dental Claim Form to be completed by *your dentist* with *your* *GMS* ID number.
- 4. When a Claim Must be Submitted** – claims must be submitted within 12 months of the date of *service* and no later than 31 days following the *expiry date* of the *policy*.

GENERAL CONDITIONS

The following general conditions apply to all benefits and *add-on coverage options* detailed under this *policy*:

1. Eligibility Requirements

The following requirements must be met to be eligible to purchase coverage and to continue to be eligible for coverage, under this *policy*:

- a) Unless otherwise provided under this *policy*, *you* must be a *Canadian resident* aged 18 to 99 (renewable for customers 100 and above);
- b) *You* must be covered under provincial health insurance; and
- c) Any person(s) on the *policy* must be related to *you* in one of the following ways:
 - i. is *your spouse* (only one *spouse* is covered);
 - ii. Living with *you* in a conjugal relationship and presented as *your spouse* or *partner* (cohabitation period of 12 months); or
 - iii. A *child* born to *you*, adopted by *you*, a stepchild, or a *child* for whom custody has been granted pursuant to a court order, who is unmarried and entirely *dependant* on *you* for maintenance and support and who is also:
 - a. Under 21 years of age;
 - b. Under 25 years of age and attending a college or university full time; or
 - c. Is *your child*.

It is *your* responsibility to tell us when an *insured person* no longer meets the eligibility requirements.

2. Coverage Start Date

Your coverage begins as of the *policy effective date* specified in the Coverage Summary document and *your* My GMS portal.

3. Policy Evaluation Period

You have ten (10) days from the day *you* receive *your policy* confirmation by email to cancel without penalty. The *policy* will be considered null and void and any premium paid up to the end of the 10-day evaluation period will be refunded, provided no claim has been incurred. If a claim has been paid, the amount must be repaid to GMS or subtracted from the premium reimbursement before the *policy* will be deemed null and void. All other requests for termination are subject to the conditions provided for in the Statutory Conditions section of this *policy*.

4. Payment Grace Period

Customers paying annually receive a 31-day grace period for premium payments. Customers paying monthly by pre-authorized debit receive a 31-day grace period for each premium payment except for the first month. During the grace period, coverage remains in force and premiums continue to be payable by *you*. Payment of claims will be suspended until all premiums due have been paid in full. GMS reserves the right to deduct any unpaid premium from claims payment. GMS will terminate the *policy* as of the *expiry date* (as outlined in #7. *Policy Termination* in this *policy*).

5. Premiums

Premiums are due on the date shown on the *policy* confirmation or renewal notice. If paying by pre-authorized debit, *your policy* will automatically renew until written notice of cancellation is received. This request can be submitted by mail, email, or fax and must include *your* name, date of birth, GMS identification number. Providing a reason for cancelling is optional but appreciated.

The premium amount is determined according to each *insured person* on the *policy* and the province/territory in which *you* live. If a change in age puts *you* into a different age rate category, premiums are adjusted at the next *policy year*. If *you* move to another province or territory, premiums are adjusted according to the rates of the new province or territory where *you* reside and are effective on the date of the change.

Administration fees may apply in cases of Non-Sufficient Funds (NSF).

6. Right to Amend Premiums or Terms

GMS reserves the right to individually establish or amend premium rates, benefit provisions, and/or terms and conditions upon application or renewal, or with 31 days' advance notice.

7. Policy Termination

You or GMS may terminate *your policy* at any time by providing written notice as provided under the applicable Statutory Conditions. After termination, annual premiums will be refunded on a pro-rated basis of unused days; or pre-authorized payments will be stopped for the next scheduled payment when notice is received 10 business days prior to the scheduled date. If less than 10 business days' notice is given, and payment is withdrawn, GMS will refund the amount within 31 business days. In the event of a termination, the amount of any claims paid under the *policy* will be deducted from any premium refund owing to *you*.

Termination applies to all persons on the *policy*.

8. Incurred Expenses Date

Expenses are deemed to have been incurred on the date the *service* was rendered or the supply was delivered. In the case of dental *services* that require multiple visits, the incurred date will be the date of the last visit or the date a final appliance has been placed.

Expenses incurred prior to the *effective date* of this *policy* are not eligible for coverage.

9. Submitting Notice of Claim

Unless otherwise stipulated, claims must be submitted to GMS within twelve (12) months of the date of *service* to be eligible for reimbursement.

If this *policy* terminates or lapses, *insured persons* must submit any health, dental, or drug claim(s) which arose prior to the *effective date* of termination to GMS within thirty-one (31) days following the date of termination of this *policy*. Opened travel claims can be submitted up to 12 months from the date GMS was notified of a travel *medical emergency*.

10. Misrepresentations

Any material misrepresentation, provision of incorrect information, or non-disclosure of information by *you*, intentional or otherwise, will result in non-payment of any claim and terminate *your policy*.

11. Contract Types

A *policyholder* may apply for a *Single, Couple, or Family policy*.

12. Adding Dependants

You may apply to change *your policy* from *Single* to *Couple* or *Family* coverage (or vice versa) at any time. A *dependant* (*spouse* or *child*) may be added at any time by submitting an application, provided the *dependant(s)* meet eligibility requirements. Any request to add *dependants* back to the *policy* will be subject to the restriction to reapply provision outlined in item #29 of General Conditions.

My Health Coverage

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To add a newborn to the *policy* from their date of birth, *GMS* must be notified within 31 days of birth. If not notified within that time frame, coverage is effective on the date of application approval.

13. Removing Dependants

You can remove *dependants* at any time with a written request submitted to *GMS* via letter or email.

14. Continuing Coverage for Dependants

Dependants, who no longer qualify as a *dependant* under the plan, may continue coverage under a separate *GMS policy* by completing an application within 60 days of when coverage under the current *GMS policy* would no longer apply. The *dependant* will be entitled to the following:

- a. Waiting periods will be waived;
- b. *Prescription drug* benefits which are continued will not be subject to the pre-existing drug provisions upon *GMS* review; and
- c. Dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan in which they are transferring from.

15. Surviving Dependand Coverage

In the event of the primary *policyholder's* death, *GMS* will continue coverage for the surviving *spouse* and/or *dependant(s)*. To continue coverage, an application must be completed and submitted within 60 days of when coverage under the current *GMS policy* would no longer apply. Upon receiving the application, *GMS* will issue a new *policy* confirmation renaming the surviving *spouse* the *policyholder* and provide updated premium.

For approved applications:

- a. Waiting periods will be waived;
- b. *Prescription drug* benefits which are continued will not be subject to the pre-existing drug provisions upon *GMS* review; and;
- c. Dental benefits which are continued will be eligible for the equivalent dental year coverage as that provided on the plan in which they are transferring from.

16. Making Changes to Your Plan

You may request a change to the health, dental, drug, or *add-on coverage option(s)* by submitting a written request to *GMS* via letter or email within 31 days of the effective or renewal date, provided you have not made claims. Approved change requests will be added to the *policy* for the remaining term of the *policy year*. Reimbursement for claims for additional benefits purchased may be prorated for the remaining term of the *policy year*.

If increasing dental coverage, you will be placed in the same year as the tier you are moving from. Orthodontic coverage will have a 1-year waiting period for anyone upgrading into year 3 of Tier 4 dental.

Adding multi-trip travel days to your *policy* can only be done while in Canada and at time of renewal (If additional days are required when travelling outside of Canada, or if you are wanting to add *single trip* days to one *trip*, you may be able to add *single trip* days through *GMS TravelStar®* Travel Insurance).

17. Continuing Coverage from Another Insurance Plan

When applying for a *GMS policy* to replace another insurance plan issued in Canada offering similar coverage, the application must be received within 60 days of when coverage under your current *policy* would no longer apply. If approved, you may be entitled for waiting periods to be waived, with the exception of the Orthodontic waiting period (if applicable).

18. Currency

All amounts stated in this *policy* are in Canadian funds.

19. Laws Applied

This *policy* shall be interpreted and construed in accordance with the laws of the province or territory where you reside and the federal laws of Canada applicable therein.

20. Subrogation

If *reasonable and customary* expenses are incurred due to the fault of a third party, *GMS* may take legal action against the person(s) at fault in your name to recover these expenses. You hereby agree that *GMS* may do so and you agree to fully cooperate with *GMS* in any action that may be taken.

21. Advance Payments Pending Coverage Determination

The Insurer may, at its discretion, make payments on behalf of the *Policyholder* prior to completing its assessment of eligibility or coverage. Any such payments are expressly made without prejudice to the Insurer's rights under this *Policy*. Where it is determined that the *Policyholder* is not eligible for coverage, or that the claim or expense is not covered, the *Policyholder* agrees to promptly repay the Insurer, upon demand, all amounts paid by the Insurer in respect of such claim or expense. The making of any advance payment shall not operate as a waiver, estoppel, or admission of liability, and shall not limit or affect the Insurer's right to deny coverage or recover such amounts.

22. Incorrect Claim Payments

Payment of any amount by *GMS* on your behalf does not constitute a guarantee that *GMS* will cover your expenses if *GMS* determines you have no coverage under this *policy*. You must repay, on demand, any amount paid or authorized by *GMS* on your behalf should *GMS* determine the amount was not payable under the terms and conditions of your *policy*.

23. Excess Coverage to Other Insurance Plans

This *policy* is in excess of all other insurance plans or amounts recoverable by any other party. If *GMS* pays eligible expenses to you and a third party makes payment for those same benefits, you are responsible for reimbursing *GMS* the amount previously paid by *GMS*. Benefits are payable only for amounts in excess of what would normally be payable under *government plans* as they exist as of the *effective date* of this *policy*.

There is no coverage for any benefits of any nature provided by a *government plan* on the *effective date* of this *policy*, regardless of whether such benefits continue to be provided by a *government plan* at the time a claim is made.

24. Duplication of Services

No benefit will be paid for or provided that is a duplication of any *service*, allowance, or reimbursement supplied by an existing government health insurance plan or private plan.

25. Publicly Funded Support Programs

When requested by *GMS*, you must apply for all publicly funded support programs that exist or may come to exist during the *policy year*. Failure to apply may result in reimbursement delays.

26. Authorization

By purchasing this *policy*, you authorize the following:

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

My Health Coverage

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- b) You authorize *GMS* to collect, store, and use any information which is provided by you and any information obtained pursuant to clauses a) and c).
- c) You authorize *GMS* to obtain information from, or disclose information to, any *government health plan*; the operator of any *hospital*, clinic, or other health facility; a *physician* or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required. Obtaining and/or disclosing this information is intended for administering your plan and communicating with you.
- d) Subject to legal or contractual restrictions, upon reasonable written notice to *GMS* you may 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 may restrict *GMS's* ability to administer your plan. Further, if you withdraw your consent, *GMS* may not be able to offer you products and services and you may limit *GMS's* ability to pay your claim(s).

27. Right to Designate a Person

GMS reserves the right to restrict or deny your right to designate a person to whom insurance money is payable.

28. Statutory Limitation

Every action or proceeding against *GMS* for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta, British Columbia, and Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or other applicable legislation.

29. Cooperation

You agree to fully cooperate with *GMS* and 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.

30. Restriction to Reapply

Following any cancellation of the *policy* by you, re-application for a *GMS* Personal Health Coverage plan, including options, is restricted for a two-year waiting period unless the new application is medically underwritten before acceptance and one of the following reasons for cancellation apply:

- a. Coverage was replaced by a new group health *policy*, without a lapse;
- b. Coverage was replaced by a new *GMS policy*, without a lapse; or
- c. Cancellation was requested due to death, separation or divorce from an insured *spouse* and new coverage is applied for with *GMS*, without a lapse.

NOTE: Items a, b and c require proof of no lapse in previous coverage.

31. Coordination of Benefits

Benefits payable to you will be directly reduced by any amount payable under a *government plan*.

If you are entitled to benefits for the same expenses under another plan, contract, or *policy*, included, 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, benefits will be coordinated in accordance with the Canadian Life & Health

Insurance Association Guidelines to the extent applicable, so that the total benefits from all plans will not exceed 100% of eligible expenses.

If the other responding contract or plan does not contain a coordination of benefits provision, the coordination of benefits provision in this *policy* will take precedent and determine the coordination of benefits between plans.

If the other plan contains a coordination of benefits provision, priority goes to the plan in the following order:

- 1) The plan where the *insured person* is covered as a member.
- 2) If the *insured person* is a member of two plans, priority goes to:
 - a. The plan where the *insured person* is an actively at work on a full-time basis;
 - b. The plan where the *insured person* is actively at work on a part-time basis; or
 - c. The plan where the *insured person* is a retiree;
- 3) The plan where the *insured person* is covered as a *spouse*;
- 4) The private plan or Individual Health Plan where the *insured person* is covered as a member.

Claims for *dependant child(ren)* should be submitted in the following order:

- 1) To the plan of the parent who has the earlier birth date in the calendar year, without consideration of the year of birth,
- 2) If the parents have the same birth date, to the plan of the parent whose first names begins with the earlier letter in the alphabet;

The following order applies to situations where parents are separated or divorced, and do not share custody:

- a. The plan of the parent with custody of the *child(ren)*;
- b. The plan of the *spouse* of the parent with custody of the *child(ren)*;
- c. The plan of the parent not having custody of the *child(ren)*; or
- d. The plan of the *spouse* of the parent not having custody of the *child(ren)*.

If the plan provided by this *policy* is determined to be the primary payor, *GMS* shall provide benefits without regard to any other *policy* or plan. If the plan provided by this *policy* is not the primary payor, *GMS* shall provide benefits only to the extent that payment on a particular claim cannot exceed 100% of eligible expenses.

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions apply to Health (including *Prescription Drug*), Travel, and Dental benefits provided under this *policy*:

1. Risky Activities

GMS does not cover medical expenses resulting from *your* participation in:

- a. Professional sport;
- b. Speed contests or racing of motorized land, water or air vehicle(s); and/or
- c. An extreme sport, including but not limited to: scuba diving (except when you are NAUI, PADI, ACUC or SSI certified), bungee jumping, parachuting, mountaineering, skydiving, participation in a rodeo, hang gliding, acrobatic or stunt flying or participating in a horse race as a jockey. NOTE: This is not an exhaustive list. Other activities may be included at GMS's discretion.

2. Criminal or Illegal Activity

GMS does not cover any medical expenses resulting directly or indirectly from *your* criminal or illegal acts.

3. Motor Vehicle Accident

GMS does not cover any medical expenses resulting from a motor vehicle *accident*, unless not covered by any other *policy*.

4. Workplace Injury or Accidents

GMS does not cover any expenses related to workplace injury or workplace *accidents*.

5. Medically Necessary

GMS does not cover any medical *services* and supplies not *medically necessary*. GMS's opinion is final and binding.

6. Unapproved Treatment

GMS does not cover *treatment, services, or supplies* that:

- a. Contravene or are prohibited by the provincial laws of *your province/territory of residence* or the federal laws of Canada; or
- b. Are experimental in nature or not considered to be effective. GMS's opinion is final and binding.

7. Result of Conflict

GMS does not cover any medical expenses resulting from *war, terrorism, or acts of foreign rebellion*.

8. Cosmetic Services

GMS does not cover any charges for medical expenses for cosmetic purposes.

9. Government Health Plan

GMS does not cover amounts payable under any government health insurance plan, regardless of whether the *insured person* is actually covered under the *government plan*.

STATUTORY CONDITIONS

Despite any other provision of this *policy*, the *policy* is subject to the statutory conditions in the applicable Insurance Act respecting contracts of *accident* and sickness insurance of the Canadian province or territory where the *policy* was issued.

(See attached Provincial/Territorial Statutory Conditions)

DEFINITIONS

The following definitions apply to all health plan types and *add-on coverage options*.

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

add-on/add-on coverage options – *Hospital Cash and Travel Days add-on*.

benefit effective date – The date a benefit becomes effective under this *policy*, following any waiting periods that may apply.

Canadian resident – A person who has a provincial/territorial government health care plan and;

- a. Is a Canadian citizen residing in Canada; or
- b. Is a permanent resident residing in Canada; or
- c. Holds a valid work or study permit in Canada.

child/children – *You or your spouse's* offspring, including *stepchild(ren)*, *adopted child(ren)* or a *child/children* for whom custody has been granted pursuant to an Order of the Court. The individual must be:

- a. Under twenty-one (21) years of age and not working more than thirty (30) hours per week unless a full-time student;
- b. Under twenty-five (25) years of age if the *child* is a full-time student in Canada, enrolled in at least three classes per semester or 60% of a full course load in an educational training facility; or
- c. Physically disabled or mentally incapable of self-support and became incapable of self-support while entirely *dependant* on *you* while eligible under a. Or b. If satisfactory proof of disability is received within thirty-one (31) days of the *child* attaining the ages indicated above to ensure continuing eligibility. To be disabled for the purposes of this definition, a *child* must be considered disabled due to a permanent mental or physical infirmity and incapable of self-support due to a medically diagnosed physical or psychiatric condition.

contracted – Describes an agreement where there is reference to a destination, a date, and/or the time and place of arrival and/or departure for a *trip*.

couple – Two people living in a spousal relationship, or a parent and a *dependant*.

dental fee guide – The current dental association fee guide of the primary *policyholder's* province/territory of residence, including amounts listed for licensed *services*. If *your* province/territory of residence does not have a *dental fee guide*, the *dental fee guide* adopted by GMS shall apply.

dentist – A person duly licensed to practice general dentistry. For 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*.

dependant:

- a. *policyholders' spouse*;
- b. any unmarried *child* of the *policyholder* or the *policyholder's* spouse.

diagnosis – The identification of medical conditions, illness, or injury through investigation or analysis of signs and symptoms.

eligible drugs – see *formulary*

effective date – *your* personal health *policy* will be effective based on the later of the following:

- a. The date on which GMS has accepted *your* application and payment has been received by GMS;
- b. The date chosen by the *policyholder* as indicated on the application, subject to GMS' acceptance of the application and receipt of payment; or
- c. The date on which the plan renews, and payment has been received by GMS.

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

family – The type of coverage provided for the *policyholder* and two or more eligible *dependants*.

family member – A *family member* may include a legal or common-law *spouse*, parent, brother, sister, legal guardian, stepparent, stepchild, stepbrother, stepsister, grandparent, grandchild, in-law, or natural or adopted *child*.

formulary – Identifies the drugs that are eligible on the *prescription drug* benefit.

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

GMS Travel Assistance – The assistance *service* provider appointed by GMS to perform all assistance *services* where indicated under this *policy*.

government plan or government health plan – The health insurance coverage that the provincial or territorial governments provide to residents of the province or territory.

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

hospital – An institution licensed, accredited, or otherwise officially designated as a *hospital*; and which is primarily engaged in providing medical, diagnostic, and surgical *services* for the care and *treatment* of sick or injured persons on an in-patient basis; and which has a laboratory, a registered graduate nurse, and a *physician* always on duty, and an operating room where surgical operations are performed by *physicians*.

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

insured person – The *policyholder* and/or any *dependants* covered by the insurance *policy*.

medical consultation – The act of meeting with a *physician* for the purpose of discussing and evaluating signs or symptoms to diagnose a medical condition, illness, or injury; or for the purpose of evaluating progress and medical *treatment* of a medical condition, illness, or injury.

medical emergency – A sudden and unforeseen medical condition that requires immediate medical *treatment*. In the case of an emergency incurred during a *trip*, a *medical emergency* no longer exists when the evidence reviewed by *GMS Travel Assistance* indicates that no further

medical *treatment* is required, at destination or you can return to your province/territory of residence for further medical *treatment*.

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

nurse practitioner – A registered nurse qualified to treat certain medical conditions without the direct supervision of a doctor.

partner – A common-law partnership where a *couple* (whether same-sex or opposite-sex) is living together for at least 12 consecutive months in a conjugal relationship.

physician – A duly qualified Doctor of Medicine, entitled under the laws of the province/territory, state, or country where the *services* are rendered, to practice medicine and surgery without restriction. This definition does not include a naturopath, herbalist, or homeopath.

policy – A contract between the *policyholder* and *GMS*, including collectively these terms and conditions, the renewal letter, the renewal confirmation letter, the applicable schedule(s) of benefits, endorsements (if any), amendments (if any), the application of the *policyholder* and any other applications which any *insured person* may be required to submit to be eligible for coverage under this *policy*.

policyholder – A person in whose favour an insurance *policy* is issued.

policy year(s) – 365 days including the *effective date* of the *policy*; or 366 days during a leap year.

prescription drug(s) – A licensed medicine regulated by legislation to require a prescription before it can be obtained and to which a Drug Identification Number (DIN) has been assigned by Health Canada. *Prescription drugs* are distinct from over-the-counter drugs, which can be obtained without a prescription. When referring to a *prescription drug* for a specified condition, it includes, but is not limited to, those drugs prescribed for the direct medical *treatment* of a diagnosed condition, the medical *treatment* of the symptoms associated with a diagnosed condition, and the prevention of symptoms associated with a diagnosed condition.

province/territory of residence – The province or territory of Canada you have declared as your permanent residence and that you reside in for the required number of outlined by your provincial/territorial health care legislation and/or *government health plan*, in order to maintain your provincial or territorial health insurance coverage.

reasonable and customary – Charges that are reasonably comparable, as determined by *GMS*, to those normally charged for the applicable goods or *services* in the particular area where the goods or *services* are purchased or received (refer to your My *GMS* portal for specific information).

return date – The date on which you are *contracted* to return to Canada.

service(s) – *Treatment(s)* performed by a licensed health practitioner within the scope of practice as defined under its professional association.

single – One person.

special status – *Prescription drugs* that are granted special coverage under your province/territory of residence's drug *formulary* when a person meets certain criteria as outlined by that drug *formulary*.

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

by the *policyholder* as the *policyholder's spouse*. A *policyholder* may only have one *spouse* covered on the *policy* at any given time.

stable – A medical condition is considered *stable* and controlled only when all of the following statements are true:

1. There has not been any new medical *treatment* prescribed or recommended, nor change(s) to existing medical *treatment* or stopped medical *treatment*; and
2. There has not been any change to any existing prescribed drug (including an increase, decrease, or stopping to prescribed dosage), except:
 - a. A dosage adjustment for anti-hypertensive or cholesterol lowering medication;
 - b. A change from brand name medication to generic medication and vice versa of the same dosage;
 - c. Coumadin/Warfarin prescribed as an anticoagulation therapy adjusted to ensure INR is maintained within therapeutic range as directed by your *physician(s)*, provided there has been no other change in your condition; and
 - d. Insulin or oral anti-diabetic medication or Ozempic and comparable drugs (i.e., GLP1 medications) where blood levels are tested on a regular basis and dosage adjustments are made to ensure your blood glucose level is maintained within therapeutic range as directed by your *physician(s)*, provided there has been no other change in your condition; and
3. The medical condition has not become worse; and
4. There have not been any new, more frequent, or more severe symptoms; and
5. There have not been any hospitalizations or specialist referrals; and
6. There have not been any tests, investigations, or medical *treatments* recommended, but not yet complete, nor any outstanding test results.

sum insured – The maximum sum payable, selected at the time of purchase, or which applies automatically to, a given insurance coverage.

transportation – Economy class transport on a common carrier, whether by land, air, or sea.

terrorism – An act, including but not limited to, the use of force or violence and/or the threat thereof, including hijacking or kidnapping, of an individual or group in order to intimidate or terrorize any government group, association, or the general public for religious, political, or ideological reasons or ends. This definition does not include any act of war, act of foreign enemies, or rebellion.

treatment(s) – Any medical, therapeutic, or diagnostic measure prescribed or recommended by a *physician* in any form, including *prescription drugs*, investigative testing, hospitalization, surgery, or other prescribed or recommended action directly referable to the applicable condition, symptom, or problem.

trip – as referred to under travel coverage is the entire period of travel *contracted* by you.

unit(s) – Time, measured in 15-minute increments, applicable to dental procedures.

war – Armed conflict, regardless of whether war has been declared, between nations or factions within a nation.

you/your – Any person eligible for coverage for any benefit under this *policy*.

My Health Coverage

Some words in this policy have very specific meanings, which are set out in the Definitions section. These words appear in italics throughout this policy document.

Group Medical Services

2055 Albert Street, PO Box 1949

Regina, SK S4P 0E3

toll-free 1.800.667.3699 email info@gms.ca

www.gms.ca



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