GMS

TRAVELSTAR® TRAVEL INSURANCE

Emergency Medical Coverage Policy Wording

Effective September 1, 2014

IMPORTANT NOTICE

What is Travel insurance?

- Travel insurance is designed to cover losses resulting from sudden, unexpected and unforeseeable circumstances. It is important that *you* read and understand *your* policy before *you* travel as *your* coverage may be subject to certain exclusions or limitations.

What is not covered?

- *Your* policy may not provide coverage for *medical conditions* and/or symptoms that existed before *your trip*. Check to see how this applies in *your* policy and how it relates to *your departure date*, date of purchase or *effective date*.

What should I expect if I have to make a claim?

- *Your* policy provides travel assistance for medical emergencies. Regardless of *your* plan's *deductible* level, if *you* experience a *medical emergency*, *you* must notify our assistance centre prior to treatment, where possible, and no later than twenty-four (24) hours after receiving *medical treatment* or being admitted to *hospital*. *Your* policy may limit benefits should *you* not contact the assistance centre.
- In the event of an *accident*, injury or sickness, *your* prior medical history shall be reviewed when a claim is made.
- In the event of a claim, *you* shall be asked to provide proof of travel dates, original expense invoices and proof of ownership/value of personal belongings.
- Refer to the Making a Claim section to understand *your* obligations when making a claim.

What happens if there is a change in my health after I apply for coverage?

- Should any changes in *your* health occur after the *application date* and prior to the *effective date*, *GMS* must be contacted and the application updated. Changes in *your* health may affect *your* coverage or void *your* policy.

This policy contains words printed in italics indicating they are defined terms detailed in the Definitions section.

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

PLEASE READ YOUR POLICY CAREFULLY BEFORE YOU TRAVEL

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For medical emergencies we're available 24-hours a day, 7 days a week.

toll-free 1.800.459.6604 (within Canada & US)

collect 905.762.5196 (all other locations)

In the event of an emergency GMS provides travel assistance. Regardless of your plan's deductible level, failure to contact GMS at the time of an emergency may limit benefits to the lesser of 70% of *reasonable and customary* expenses or $50,000. Please refer to the Managing a Medical Emergency section of this policy for more information.

For general inquiries call toll-free 1.800.667.3699 or email info@gms.ca

EMERGENCY MEDICAL COVERAGE

Emergency medical coverage may be purchased as a Single-Trip plan, or as a Multi-Trip Annual plan providing limited coverage for multiple *trips* taken throughout the year. The following benefits and exclusions are applicable to both plans. Refer to the Single-Trip or Multi-Trip Annual sections for details on eligibility, when coverage begins and ends, policy changes, and refunds as they apply to the plan *you* select.

Benefits

In the event of a *medical emergency* that occurs outside of *your province of residence*, unless otherwise stated, *GMS* will pay *reasonable and customary* expenses on *your* behalf, up to $5,000,000 CAD, as described in the plan type chosen. Where a listed benefit indicates a maximum limit, the limit is applied per *trip* regardless of the number of claims incurred.

1. **In-Hospital Care** – expenses for:
   a. ward or semi-private *hospital* accommodations;
   b. *hospital* services and supplies; and
   c. *medical treatment* while in-*hospital*.

   One follow-up visit is covered if it is deemed medically necessary and directly related to the covered *medical emergency*. The follow-up visit must occur within fourteen (14) days of discharge. This benefit does not provide coverage for ongoing treatment necessary to treat any *medical condition* once the *medical emergency* has ended.
2. **Medical Services** – expenses for *medical treatment* from a *physician*.
3. **Diagnostic Services** – expenses for basic diagnostic tests. Pre-approval by *GMS* is required for advanced diagnostic testing, including but not limited to, magnetic resonance imaging, computerized axial tomography scans, sonograms, ultrasounds, and biopsies.
4. **Out-Patient Medical Treatment** – expenses for out-patient *medical treatment*.
5. **Prescription Drug** – expenses for *prescription drugs* prescribed by an attending *physician* and supplied by a licensed pharmacist. *GMS* covers a maximum supply of thirty (30) days per prescription. Over-the-counter medication is not covered whether it has been prescribed or not.

   Prescription drugs that are lost, stolen or damaged during *your trip* are covered up to a maximum of $50 per prescription. *Physician*'s expenses related to replacement are not covered.
6. **Rental of Essential Medical Appliances** – expenses for the rental of essential medical appliances (wheelchair, crutches, canes etc.) when needed due to a *medical emergency* that occurred on *your trip*. The rental expense must not exceed the cost to purchase the appliances. Pre-approval by *GMS* is required.
7. **Emergency Dental Services** – expenses, to a maximum of $2,000, due to an *accidental* blow to the mouth that requires the repair or replacement of natural teeth or permanently attached artificial teeth. Expenses to a maximum of $250 are also covered for the treatment or the relief of dental pain for any dental emergency other than that caused by an *accidental* blow to the mouth.
8. **Private Duty Nursing** – expenses to a maximum of $5,000 for private duty nursing services performed by a 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 by *GMS* is required.
9. **Health Practitioners** – expenses to a maximum of $300, per specialty, for the services of an osteopath, physiotherapist, chiropractor, chiropodist, or podiatrist.
10. **Road Ambulance** – expenses for the use of a licensed road ambulance in a *medical emergency* where *you* require immediate transport to the nearest *hospital* with adequate facilities.
11. **Air Ambulance** – expenses to a maximum of $20,000 for the use of a helicopter air ambulance in a *medical emergency* involving life threatening circumstances where *you* require immediate transport to the nearest *hospital* with adequate facilities to treat *your medical emergency*. Pre-approval by *GMS* is required for transport between *hospitals*.
12. **Remote Evacuation** – expenses to a maximum of $20,000 for *your* evacuation to the nearest, most accessible *hospital* from a location inaccessible by road in a *medical emergency* involving life threatening circumstances.
13. **Repatriation** – expenses to transport *you* by air ambulance (excluding helicopters) or regularly scheduled *common carrier* back to *your province of residence* for further in-*hospital medical treatment*, with written recommendation from the attending *physician* confirming that *you* are fit to travel. Pre-approval by *GMS* is required.
14. **Special Attendant** – expense of round-trip *transportation* for the transport of a medical attendant to accompany *you* back to *your province of residence* when ordered by the attending *physician*. The attendant must not be a friend, *family member*, associate or *travelling companion*. Pre-approval by *GMS* is required.
15. **Return of Family Member** – expenses up to $1,000 for one-way air *transportation* to return one (1) accompanying *family member* insured under *your* policy to *your province of residence* when:
    a. *GMS* requires that *you* return to *your province of residence* for further in-*hospital medical treatment*; or
    b. in the event of *your* death.

    Pre-approval by *GMS* is required.
16. **Return & Escort of a Dependent Child/Grandchild** – expense of one-way *transportation* to return *your* dependent children, or grandchildren travelling with *you*, who are under the age of eighteen (18) to *your province of residence* when *you* have been returned to *your province of residence* for further in-*hospital medical treatment*. When necessary, round-*trip transportation* for an arranged escort will be provided for under this benefit. Pre-approval by *GMS* is required.
17. **Family/Friend to Bedside** – expenses to a maximum of $3,000 for round-*trip* air *transportation* for a *family member* or a close friend to visit *you* if *you* are travelling without a *family member*, on night three (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.
18. **In Event of Death** – expenses up to $2,000 for round-*trip* air *transportation* to provide for the return of a *family member* who is required to attend to identify *your* remains in the case of *your* death due to a *medical emergency*. *GMS* will also reimburse up to $300 combined for meals and accommodations incurred during travel. Pre-approval by *GMS* is required.
19. **Return of Remains** – expenses, up to a maximum of $7,000, for the preparation and transport of *your* remains to *your province of residence*, or expenses up to a maximum of $3,000 for *your* cremation or burial at the place of death, when *your* death was a result of a *medical emergency*. This benefit does not cover the cost of a burial casket or urn.
20. **Return of Vehicle** – expenses, up to a maximum of $2,000, to return *your* vehicle to *your province of residence*, or a vehicle rented by *you* to the nearest rental agency, when *you* or any *travelling companion*s are unable to do so because *you* have been returned to *your province 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.
21. **Return of Cat or Dog** – expenses to a maximum of $300 to return *your* cat or dog to *your province of residence*, when *you* have been returned to *your province of residence* for further in-*hospital medical treatment*.
22. **Child Care** – expenses to a maximum of $500 for licensed care of dependent children/grandchildren or mental or physically challenged persons who rely on *you* for assistance, if they are travelling with *you*, should *you* require in-*hospital* care. Pre-approval by *GMS* is required.
23. **Out-of-Pocket Expenses** – expenses up to a maximum of $1,000 incurred by a *travelling companion* insured under *your* policy in the event *you* are in *hospital* receiving care on *your return date*. This benefit includes coverage for up to $150/day for accommodations, which shall form part of the $1,000 limit. Pre-approval by *GMS* is required.
24. **Coverage Continuation** – when an unexpected event occurs requiring *you* to return early from *your trip*, *GMS* will continue *your* coverage at no additional premium when *you* resume *your trip* prior to *your return date*. This does not apply if *you* are returned to *your province of residence* as a result of *your medical emergency*. There is no refund for unused periods of coverage. Costs to return to *your province of residence* or to *your trip* destination are not recoverable. Any *medical treatment* or *medical consultation* received during the return to *your province of residence* must be reported to *GMS* prior to resuming *your trip* and may impact *your* eligibility and/or may void *your* policy.

GMS is not responsible for the availability, quality, results or effectiveness of any *medical treatment*, *transportation* or other service or *your* failure to obtain *medical treatment*.

Exclusions

1. **Stability** – *GMS* does not cover any expenses resulting from *medical condition*(s) which have not been *stable* for one hundred and eighty (180) days immediately prior to *your departure date*, including:
   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. **Stability When Topping-Up Other Insurer's Plans** – *GMS* does not cover any expenses where this policy is being used as a top-up for another insurer's emergency medical insurance, unless the *medical conditions* have been *stable* for one hundred eighty (180) days prior to the *effective date* of the top-up.
3. **Stability When Topping-Up a GMS Plan** – *GMS* does not cover any expenses where this policy is being used as a top-up to existing *GMS* emergency medical coverage, unless *medical conditions* are *stable* as defined by the stability period as specified within the *GMS* policy this policy is topping-up.
4. **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*.

5. **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 examinations; 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.*
6. **Travel for Diagnosis or Treatment** – *GMS* does not cover any expenses resulting from and/or incurred during *trip*s undertaken for the purpose of receiving a *diagnosis* or *medical treatment*.
7. **Delay-able Treatment** – *GMS* does not cover any expenses for *medical treatment* that can be reasonably delayed until *you* return to *your province of residence*.
8. **Transplants** – *GMS* does not cover any expenses for transplants, including but not limited to organ transplants, or bone marrow or stem cell transplants which may be required as part of *your medical treatment* provided at *your trip* destination.
9. **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 of residence* when deemed medically necessary. Refusal to comply with a transfer request or a request to return to *your province of residence*, when *you* could have been returned to *your province of residence* without endangering *your* life or health, even if the treatment available in *your province of residence* could be of lesser quality than the treatment available outside *your province 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.
10. **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*.
11. **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.
12. **Acting Against Physician's Advice** – *GMS* does not cover any expenses when *you* travel against the advice of a *physician*.
13. **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 eighteen (18) weeks of pregnancy.
14. **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*.
15. **Risky Activities** – *GMS* does not cover any expenses resulting from *your* participation in:
    a. professional sport;
    b. speed contests or racing of motorized land, water or air vehicle(s);
    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, rodeo, hang gliding, acrobatic or stunt flying or jockeying.
16. **Non-Common Carrier Air Travel** – *GMS* does not cover any expenses resulting from air travel unless riding as a passenger on a *common carrier*.
17. **Certain Pre-Existing Conditions** – *GMS* does not cover any expenses related to a pre-existing *diagnosis* that is emotional, psychological or psychiatric in nature.
18. **Work** – *GMS* does not cover any expenses for work related *accidents*.
19. **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.
20. **Result of Conflict** – *GMS* does not cover any expenses resulting from *war*, *terrorism* or acts of foreign rebellion.
21. **Travel Advisory** – *GMS* does not cover expenses arising from any *medical conditions* occurring while *you* are travelling in a country, region, or city for which Foreign Affairs and International Trade Canada has issued a travel warning stating that "non-essential" or "all travel" be avoided when such travel advisory is issued prior to *your* departure.
22. **Self-harm** – *GMS* does not cover any expenses resulting from suicide or self-inflicted injuries.
23. **Criminal or Illegal Activity** – *GMS* does not cover any expenses resulting directly or indirectly from *your* criminal or illegal acts.
24. **Drugs & Alcohol** – *GMS* does not cover any expenses resulting from *your* sickness, injury, or death if at the time of the sickness, injury, or death evidence supports that it was caused by, or in any way contributed to, by the use or abuse of prohibited drugs, alcohol, or any other intoxicant or the misuse of a medication, whether prescribed or not.
25. **Motor Vehicle Accident** - *GMS* does not cover any expenses resulting from a motor vehicle *accident*, unless not covered by any other policy.
26. **Failure to Obtain GMS Pre-Approval** – *GMS* does not cover any expenses where pre-approval by *GMS* is required and not obtained.
27. **Unapproved Treatment** - *GMS* does not cover any expenses for *medical treatment* or services that contravene or are prohibited by the provincial laws of *your province of residence* or the federal laws of Canada.
28. **Pre-Existing Nuclear Issues** – *GMS* does not cover any expenses resulting from any nuclear reaction, radiation or radioactive contamination or occurrence, where the risk of the exposure was present prior to *your* departure, however caused.
29. **Experimental Treatment** – *GMS* does not cover any expenses for any *medical treatment* which is considered by *GMS* to be experimental. *GMS*' opinion is final and binding.

Managing a Medical Emergency

Regardless of *your* plan's *deductible*, in the event of a *medical emergency*:

1. *You* must contact *GMS Travel Assistance* where possible before *you* seek *medical treatment*. *GMS Travel Assistance* will:
    a. offer telephone interpretation services in many languages;
    b. monitor progress during *your medical consultation* and *medical treatment*; and
    c. coordinate all *medical treatment*, transport, and repatriation.
2. *You* are required to contact *GMS Travel Assistance* within twenty-four (24) hours of receiving *medical treatment* or admission to *hospital*. Failure to do so may limit benefits to the lesser of 70% of *reasonable and customary* expenses or $50,000.

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

Making a Claim

In the event of a claim, a claim form must be submitted to *GMS* within ninety (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 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 to obtain documents or reports to support *your* claim are not covered.

Application of Deductible

GMS will reimburse *you* up to the maximum *sum insured* for eligible expenses incurred per *trip* in excess of the *deductible* shown on *your* TravelStar application.

Authorization

You authorize *GMS* to receive reports about *your medical treatment* from any *physician*, service provider, person, *hospital* or institution. For more details see *GMS*' privacy policy at www.gms.ca.

SINGLE-TRIP PLAN

The Single-Trip plan provides coverage for one *trip* with a specified *departure date* and *return date*. It offers *medical emergency* coverage to a maximum of $5,000,000 CAD per insured person, for *reasonable and customary* expenses incurred by *you*, in the event of a *medical emergency* that occurs outside of *your province of residence*.

GMS will pay *reasonable and customary* expenses in excess of applicable *deductible*s and all other group, individual, private or *government health plan*s or contracts of insurance according to the terms and conditions of this policy.

Eligibility

All applicants are subject to this Eligibility section. If *you* are sixty (60) years of age or older *you* must complete both the Eligibility and Medical Questionnaire portions of the application when *you* apply.

If any of the following conditions apply on the *application date*, *you* are not eligible for the Single-Trip plan.

1. *You* are not eligible if *you*:
    a. have an Implantable Cardioverter Defibrillator (ICD);
    b. have ever been diagnosed with congestive heart failure (CHF);
    c. are awaiting further tests or treatment for heart disease which includes but is not limited to angina, irregular heartbeat, heart attack, ischemic heart disease, valvular heart disease and myocardiopathy;
    d. require insulin to treat diabetes and also take *prescription drugs* for heart disease (see (c) above for heart disease description);
    e. have been diagnosed with metastatic cancer;
    f. have cancer (except breast or prostate cancer treated exclusively with hormonal therapy or basal cell carcinoma) which requires chemotherapy, radiotherapy or other *medical treatment* other than routine follow-up;
    g. have any vascular aneurysm that remains surgically untreated;

h. have undiagnosed episodes of fainting or falling (syncope);
i. take oral steroids for a lung condition;
j. are seventy (70) years of age or older and require assistance from another person(s) with activities of daily living (ADL) which include, but are not limited to, personal hygiene and grooming; dressing and undressing; self-feeding; functional transfers (getting into and out of bed or a wheelchair, getting onto or off the toilet, etc.); bowel and bladder management; and/or medication management; or
k. have any *medical condition* necessitating the use of home oxygen.

2. *You* are not eligible if, within the twelve (12) months prior to applying, *you* have been diagnosed with any of the following conditions or *you* have any of the following conditions which have not been *stable* for twelve (12) months prior to applying:
   a. Acquired Immune Deficiency Syndrome (AIDS);
   b. a terminal illness (an advanced stage of a progressive disease with an unfavourable prognosis and no known cure);
   c. atrial flutter;
   d. atrial/ventricular fibrillation;
   e. peripheral vascular disease;
   f. stroke/transient ischemic attack (TIA);
   g. blood clot(s);
   h. gastrointestinal bleeding; and/or
   i. kidney/liver failure.
3. *You* are not eligible if, within twelve (12) months of applying, *you* have undergone any of the following procedures:
   a. kidney dialysis;
   b. valve surgery or replacement; and/or
   c. organ, stem cell and/or bone marrow transplant.
4. *You* are not eligible if *you* are not a Canadian resident with valid provincial health coverage for the entire duration of *your trip*.
5. *You* are not eligible to purchase after *your departure date* or if *you* are outside of *your province of residence*, unless purchased as a top-up to an existing *GMS* policy.
6. *You* are not eligible if *your* total *trip* length exceeds the total number of days allowable under *your government health plan*.

Should any changes to *your* health occur after the *application date* and prior to the *effective date*, *GMS* must be notified and *your* application updated. A change in *your* health may:

1. affect *your* eligibility for coverage; or
2. increase *your* required premium.

Changes to *your* health that do not affect eligibility will still constitute a change in stability and may limit *your* available coverage.

FAMILY COVERAGE

Coverage for *dependants* under sixteen (16) years of age travelling with paying adults is provided at no cost. Coverage will only be provided for *dependants* under sixteen (16) if they are listed on *your* application.

Coverage Begins & Ends

Once *GMS* has accepted *your* application and *your* payment has been received by *GMS*, *your* Single-Trip plan begins on the later of the day:

1. shown on *your* application as the *contracted departure date*;
2. *you* depart from *your province of residence* to begin *your trip*; or
3. following the expiry of the policy being topped-up, when this policy is used as a top-up.

Coverage ends on the earliest of the day:

1. *you* return to *your province of residence*, except where benefit 24. applies;
2. shown on *your* application as the *contracted return date*;
3. *GMS* ends coverage for a *medical emergency* as a result of *your* failure to comply with *GMS*' option to return *you* to *your province of residence* for further *medical treatment*; or
4. *GMS* returns *you* to *your province of residence*.

Extensions & Policy Changes

Extensions and policy changes for a Single-Trip plan must be paid by credit card at time of extension or change for coverage to be in effect.

OPTIONAL EXTENSIONS

Your Single-Trip plan may be extended by purchasing additional days while outside *your province of residence* if *you*:

1. notify *GMS* two (2) business days prior to the *expiry date* of *your* policy;
2. have not incurred a claim, required *medical treatment* or *medical consultation* during *your trip*; and
3. the total *trip* length, including *your* initial period of coverage and all extensions, does not exceed the number of days allowable under *your government health plan*.

Your policy cannot be extended after the *expiry date* of a policy *you* wish to extend.

AUTOMATIC EXTENSIONS

Your Single-Trip plan will automatically be extended up to seventy-two (72) hours if the return to *your province of residence* is delayed beyond the *expiry date* of the policy due to any of the following.

1. *You* are delayed due to *your* or *your* travelling companion's *medical emergency*. Written confirmation from the attending physician is required to verify that you are medically unfit to travel. The seventy-two (72) hour extension will begin once you have been deemed medically fit to travel or discharged from the *hospital*. In-*hospital* care during the medical emergency continues to be covered by your policy until your discharge from *hospital*;
2. A delay of a *common carrier you* are travelling on causes *you* to miss *your return date* to *your province of residence*.
3. The vehicle *you* are travelling in:
   a. is involved in an *accident*;
   b. has a mechanical breakdown; or
   c. is delayed by a police directed road closure.

POLICY CHANGES

You must contact *GMS* prior to the *departure date* to:

1. make changes to travel dates;
2. make changes to *your deductible*; or
3. add or remove applicants.

Additional premium may apply and must be paid in full before any policy change will be made.

Top-ups

You may choose a Single-Trip plan to top-up a Multi-Trip Annual plan or other limited travel insurance when additional days are needed to cover *your trip*. A top-up is a new *GMS* policy which is subject to the terms, conditions, exclusions and limitations of the *GMS* policy wording. Coverage begins the day following the *expiry date* of the policy it is topping-up and must be purchased for the full number of days not covered by the insurance policy being topped-up.

When buying a top-up for an insurance policy held with a company other than *GMS you* must apply for the top-up prior to *your contracted departure date* and are subject to the stability criteria as defined in the Exclusions section of this policy.

When buying a top-up for a *GMS* policy, *you* must apply for coverage two (2) business days prior to the expiry of *your* current *GMS* policy and must not have incurred a claim or required *medical treatment* during *your trip*.

To apply *you* must complete and submit an application and, where required, a medical questionnaire to *GMS*. A minimum charge of $20 applies when topping-up another insurer's policy. When topping-up an existing *GMS* Multi-*Trip* Annual plan, daily rates apply.

Requesting a Refund

Full refunds are available when *your* policy is cancelled before *your effective date*.

If any insured person makes a claim under the family plan, i.e. when an adult is travelling with *dependants* under the age of sixteen (16) who are provided with coverage at no charge, no partial refunds are permitted.

For all others, partial refunds are available to each insured person who has not incurred a claim if returning to his/her *province of residence* prior to the *expiry date* of the policy.

To apply for a partial refund written notice with proof of early return to *your province of residence* must be received by *GMS* no later than thirty (30) days from the date *you* return.

A partial refund will be calculated using the number of unused days and the daily rate applied based on your original trip length and the refund amount payable must be in excess of $5. *You* will no longer be eligible for any claim reimbursement once a refund has been issued.

Refer to Managing a Medical Emergency for details on what constitutes a claim.

MULTI-TRIP ANNUAL PLAN

A Multi-Trip Annual plan provides annual coverage for unlimited short *trips* of either 15 or 30 days, based on the option selected. It offers coverage to a maximum of $5,000,000 CAD per insured person, per *policy year* for *reasonable and customary* expenses incurred by *you*, in the event of a *medical emergency* that occurs outside of *your province of residence*.

GMS will pay *reasonable and customary* expenses in excess of all other group, individual, private or *government health plan*s or contracts of insurance according to the terms and conditions of this policy.

Eligibility

All applicants are subject to this Eligibility section. If *you* are sixty (60) years of age or older *you* must complete both the Eligibility and Medical Questionnaire portions of the application when *you* apply.

If any of the following conditions apply on the *application date*, *you* are not eligible for the Multi-Trip Annual plan.

1. *You* are not eligible if *you* are eighty (80) years of age or older.
2. *You* are not eligible if *you*:
   a. have an Implantable Cardioverter Defibrillator (ICD);
   b. have ever been diagnosed with congestive heart failure (CHF);
   c. are awaiting further tests or treatment for heart disease, which includes but is not limited to angina, irregular heartbeat, heart attack, ischemic heart disease, valvular heart disease and myocardiopathy;
   d. require insulin to treat diabetes and also take *prescription drugs* for heart disease (see c. above for heart disease description);
   e. have been diagnosed with metastatic cancer;
   f. have cancer (except breast or prostate cancer treated exclusively with hormonal therapy or basal cell carcinoma) which requires chemotherapy, radiotherapy or other *medical treatment* other than routine follow-up;
   g. have any vascular aneurysm that remains surgically untreated;
   h. have undiagnosed episodes of fainting or falling (syncope);
   i. take oral steroids for a lung condition;
   j. are seventy (70) years of age or older and require assistance from another person(s) with activities of daily living (ADL) which include, but are not limited to, personal hygiene and grooming; dressing and undressing; self-feeding; functional transfers (getting into and out of bed or a wheelchair, getting onto or off the toilet, etc.); bowel and bladder management; and/or medication management;
   k. have any *medical condition* necessitating the use of home oxygen.
3. *You* are not eligible if, within the twelve (12) months prior to applying, *you* have been diagnosed with any of the following conditions or *you* have any of the following conditions which have not been *stable* for twelve (12) months prior to applying:
   a. Acquired Immune Deficiency Syndrome (AIDS);
   b. a terminal illness (an advanced stage of a progressive disease with an unfavourable prognosis and no known cure);
   c. atrial flutter;
   d. atrial/ventricular fibrillation;
   e. peripheral vascular disease;
   f. stroke/transient ischemic attack (TIA);
   g. blood clot(s);
   h. gastrointestinal bleeding; and/or
   i. kidney/liver failure.
4. *You* are not eligible if, within twelve (12) months of applying, *you* have undergone any of the following procedures:
   a. kidney dialysis;
   b. valve surgery or replacement; and/or
   c. organ, stem cell or bone marrow transplant.
5. *You* are not eligible if *you* are not a Canadian resident with valid provincial health coverage.
6. *You* are not eligible to purchase after *your departure date* or outside *your province of residence*.

For a *trip* to be eligible for coverage under the Multi-Trip Annual plan, it must meet the following conditions on the booking date of the *trip*.

1. *You* must ensure that *you* have valid provincial health coverage for the duration of each *trip*.
2. Expenses related to *medical conditions you* experience after the *effective date* of *your* Multi-Trip Annual plan but prior to the *departure date* of any *trip* may be limited based on exclusions related to pre-existing *medical conditions*. Please read *your* policy carefully and refer to the Exclusions section.

Should any changes to *your* health occur after the *application date* and prior to the *effective date*, *GMS* must be notified and *your* application updated. A change in *your* health may:

1. affect *your* eligibility for coverage; or
2. increase *your* required premium.

Changes to *your* health that do not affect eligibility will still constitute a change in stability and may limit *your* available coverage.

Coverage Begins & Ends

Once *GMS* has accepted *your* application and *your* payment has been received by *GMS*, *your* Multi-Trip Annual plan begins on the *effective date* as chosen by *you* on *your* application.

Your Multi-Trip Annual plan ends on the last day of the *policy year*.

Multi-Trip Annual plan coverage begins for each *trip* on *your departure date* from *your province of residence* and ends for each *trip* on the earlier of the following day:

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

Extensions & Policy Changes

Policy changes for a Multi-Trip Annual plan must be paid by credit card at time of extension or change for coverage to be in effect.

Your Multi-Trip Annual plan may be extended while outside *your province of residence* by upgrading *your* Multi-Trip Annual plan to cover a longer *trip* length (if available) or by purchasing additional days with the Single-Trip plan if:

1. *you* notify *GMS* two (2) business days prior to reaching the maximum *trip* length allowable under the option chosen;
2. *you* have not incurred a claim, required *medical treatment* or *medical consultation* during *your trip*; and
3. the total *trip* length, including *your* initial period of coverage and all extensions, does not exceed the number of days allowable under *your government health plan*. *Your* policy cannot be extended after its *expiry date*.

AUTOMATIC EXTENSIONS

Your Multi-Trip Annual plan will automatically be extended up to seventy-two (72) hours if the return to *your province of residence* is delayed beyond the *expiry date* of the policy due to any of the following.

1. *You* are delayed due to *your* or *your* travelling companion's *medical emergency*. Written confirmation from the attending physician is required to verify that you are medically unfit to travel. The seventy-two (72) hour extension will begin once you have been deemed medically fit to travel or discharged from the *hospital*. In-*hospital* care during the medical emergency continues to be covered by your policy until your discharge from *hospital*;
2. A delay of a *common carrier you* are travelling on causes *you* to miss *your return date* to *your province of residence*.
3. The vehicle *you* are travelling in:
   a. is involved in an *accident*;
   b. has a mechanical breakdown; or
   c. is delayed by a police directed road closure.

POLICY CHANGES

Additions or deletions of any applicant must be made prior to the *effective date* of the coverage by contacting *GMS*. Additional premium may apply and must be paid in full before any policy change will be made.

Requesting a Refund

Full refunds are available when *your* policy is cancelled before your *effective date*.

Partial refunds are available for an insured person in the event of his/her death, provided that no claims have been incurred under the policy.

To apply for a partial refund written notice with proof of death must be received by *GMS* no later than ninety (90) days from the insured person's death.

A partial refund (in the event of his/her death) will be calculated based on a prorated portion of unused days remaining in the Multi-trip Annual plan and the refund amount payable must be on excess of $5. *You* will no longer be eligible for any claim reimbursement once a refund has been issued.

Refer to Managing a Medical Emergency for details on what constitutes a claim.

ADDITIONAL COVERAGE

For an additional premium, the following additional coverage may be added to *your* Emergency Medical coverage.

Baggage Loss, Damage & Delay Coverage

Baggage Loss, Damage & Delay coverage is intended to provide additional protection for *your* personal belongings while travelling.

ELIGIBILITY

To be eligible for Baggage Loss, Damage & Delay coverage *you* must meet the following conditions on the *application date*. Baggage Loss, Damage & Delay must be:

1. purchased prior to departure; and
2. added to existing *GMS* TravelStar Emergency Medical or Trip Cancellation & Interruption coverage.

COVERAGE BEGINS AND ENDS

Once *GMS* has accepted *your* application and *your* payment has been received by *GMS*, Baggage Loss, Damage & Delay coverage will be added to *your* Emergency Medical coverage or Trip Cancellation & Interruption coverage Single-Trip or Multi-Trip Annual plan as follows.

Coverage will begin on the date *you* leave *your* residence to begin *your trip*.

Coverage ends on the later of:

1. the day *you* return to *your* primary home in *your province of residence*;
2. the day shown on *your* application as the *contracted return date*; or
3. the day *your* property is returned, when under check and delayed by a *common carrier*.

BENEFITS

Baggage Loss, Damage & Delay offers coverage to a maximum of $1,500 per person, per *trip* for losses to *your* personal belongings resulting from theft, fire or *transportation* hazards that occurred during *your trip*.

GMS will pay the following:

1. the lesser of the repair cost or actual cash value of the item after depreciation based on age and condition, but not more than:
   a. the cost to replace with an item of similar quality and value;
   b. the reasonable proportion of the total value of a set when the item was part of a set; and
   c. $500 per item or set of items;
2. $100 to replace each of the following documents:
   a. passport;
   b. driver's license;
   c. birth certificate; and/or
   d. travel visa;
3. a maximum of $100 cash, if stolen from *you*, where the theft has been reported and documented by the local police authorities; and
4. $400 for personal necessities when *your* checked baggage has been delayed for more than twelve (12) hours after *you* arrive at *your contracted* destination.

BAGGAGE LOSS, DAMAGE & DELAY COVERAGE ENHANCEMENTS

For an additional premium *you* may add increased coverage to *your* Baggage Loss, Damage & Delay coverage for the following items.

1. **Sporting Goods**: up to $2,000 for specifically identified sporting goods to be used by *you* during *your trip*.
2. **Computer Equipment**: up to $2,000 for specifically identified computer equipment to be used by *you* during *your trip*.
3. **Increased Per Item Limit**: up to $1,000 per specifically identified item or set of items to be used by *you* during *your trip*.

A full description of the item to be insured must accompany the application for coverage.

When *you* have purchased baggage coverage enhancements, *GMS* will pay the lesser of the repair cost or actual cash value of the item after depreciation based on age and condition, but not more than:

1. the cost to replace with an item of similar quality and value;
2. the reasonable proportion of the total value of a set when the item was part of a set; and
3. the maximum limit specified in the baggage coverage enhancement selected.

EXCLUSIONS

Baggage Loss, Damage & Delay coverage does not cover:

1. theft of animals, sunglasses, prescription glasses or contact lenses, jewelry, hearing aids or event tickets;
2. theft of bicycles, except while checked as baggage with a *common carrier*;
3. theft of handheld electronic devices including but not limited to MP3 players, cellular telephones and smart phones, entertainment equipment such as portable DVD players, CD players, stereo equipment, and all gaming devices;
4. theft of unaccompanied baggage or personal effects;
5. baggage or personal effects left unattended in an unlocked vehicle when the baggage or personal effects are in *your* care and control;
6. breakage of brittle or fragile articles which may be damaged as a result of a *transportation* hazard;
7. damage caused from wear and tear, deterioration, defect or mechanical breakdown;
8. expenses resulting directly or indirectly from *your* criminal, illegal or willful acts; and
9. expenses arising from loss caused by *your* imprudent act or omission.

MAKING A BAGGAGE CLAIM

In order to make a claim under Baggage Loss, Damage & Delay coverage:

1. *you* must report *your* claim to *GMS* within five (5) days of returning to *your province of residence*;
2. *you* must submit a claim form within ninety (90) days of the cause of loss;
3. *you* must take all reasonable precautions to protect, save and recover *your* property; and
4. *GMS* requires:
   a. the police report;
   b. proof of travel dates;
   c. proof of ownership and value of all items claimed; and
   d. a copy of other property insurance policies where required.

Failure to provide applicable substantiation for a claim shall invalidate any claim under this insurance.

GENERAL CONDITIONS

The following conditions apply to all insurance coverage and additional coverage purchased.

1. **Coverage Starts** - coverage is not effective until *GMS* approves the application, and the appropriate premium has been paid.
2. **Currency** - all amounts stated in this policy are in Canadian funds.
3. **Interest** - benefits payable shall not include interest charges.
4. **Laws Applied** - this policy shall be interpreted and construed in accordance with the law of the Province of Saskatchewan and the federal laws of Canada applicable therein.
5. **Subrogation** - if *reasonable and customary* expenses are incurred due to the fault of a third party, *GMS* may take legal action against the person(s) at fault in *your* name to recover these expenses and *you* hereby agree that *GMS* may do so. *You* agree to fully cooperate with *GMS* in any action that might be taken.
6. **Excess Coverage to Other Insurance Plans** - this policy is in excess only of all other insurance coverage or amounts recoverable by any other party. If *GMS* pays *reasonable and customary* 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*.
7. **Excess Coverage to Government Health Plan** - this policy is in excess of what would normally be payable under *your government health plan*. There is no coverage for any benefits provided by a *government health plan* on the policy *effective date* regardless of whether such benefits continue to be provided by a *government health plan* at the time the claim is made.
8. **Coordination of Benefits** - in the event *you* have concurrent insurance from another source(s) with respect to benefits provided under this policy, benefits shall be coordinated in accordance with the Canadian Life and Health Insurance Association guidelines, except:
   a. when retirement group health coverage exists with a lifetime limit of $50,000 or less; or
   b. where a claim is made under *GMS* Baggage Loss, Damage & Delay.
9. **Maximum Payable When Coordinating Benefits** - if a covered person is entitled to similar benefits under any other individual or group coverage, the benefits payable under this coverage shall be coordinated so that the total payment from all coverage shall not exceed the amount for which the claim is made.
10. **Right to Designate a Person** - *GMS* reserves the right to restrict or deny *your* right to designate persons to whom insurance money is payable.
11. **Right to 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 of residence* if deemed medically necessary.
12. **Maximum Payable** - insurance is in effect only for coverage and *sum insured* as indicated on *your* application for which the premium has been paid. Benefits are payable in accordance with the benefits listed in this policy and limited to the *sum insured*.
13. **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.
14. **Payment Not a Guarantee** - payment of any amount by *GMS* on *your* behalf does not constitute a guarantee that *GMS* will cover *your* expenses if *GMS* determines *you* have no coverage under this policy. *You* must repay, on demand, any amount paid or authorized by *GMS* on *your* behalf if and when *GMS* determines that the amount was not payable under the terms and conditions of *your* policy.
15. **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.
16. **Misrepresentation** - any material misrepresentation, provision of incorrect information, or non-disclosure of information by *you* will result in non-payment of any claim and will void *your* coverage.
17. **Authorization** - by purchasing this policy *you* are:
    a. authorizing any *physician*, health care provider, other person, *hospital* or institution to release to *GMS* and/or its authorized agents, representatives, affiliates or assistance service provider (collectively "*GMS*") any information covering *your* medical history, symptoms, *medical treatment*, examination, *diagnosis* and/or services rendered to *you* and or *your dependants*;
    b. authorizing *GMS* to collect, store and use any information which is provided by *you* and any information obtained pursuant to clause a. and c.;
    c. authorizing *GMS* to obtain information from, or disclose information to any *government health plan*; the operator of any clinic or other health facility; a *physician* or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required (this information is intended for the purpose of administering the policy and communicating with *you*); and
    d. acknowledging, subject to legal or contractual restrictions, *you* may (upon reasonable written notice to *GMS*), choose to withdraw *your* consent to the collection, use and disclosure of such information. If *your* consent is withdrawn, *you* will restrict *GMS*' ability to administer *your* policy. Further, if *you* withdraw *your* consent, *GMS* may not be able to offer *you GMS* products and services and *you* will limit *GMS*' ability to pay *your* claim(s).

18. **Obligation to Cooperate** - *you* agree to fully cooperate with *GMS* to provide the documentation and authorization required by *GMS* to administer *your* policy, including the assessment of *your* claims. Failure to do so with respect to the assessment of *your* claims will result in the non-payment of claims, in accordance with the General Conditions.
19. **Right if Premium is Owed** - *GMS* reserves the right to suspend claims reimbursement until such time as payment of premium in full is received. In the event of non-payment of premium, *GMS* reserves the right to terminate the policy, with notice.
20. **Policy Evaluation Period** - for Single-Trip plans greater than one hundred ninety (190) days and all Multi-Trip Annual plans with emergency medical coverage, *you* have ten (10) days from the day *you* apply for *your* policy to return it to *GMS* for cancellation. The policy will be considered null and void and any premium paid up to the end of the 10-day examination period will be refunded, provided no claim has been incurred. If a claim has been paid, the amount of the claim must be immediately repaid to *GMS*, less the premium amount, before the policy will be deemed null and void. This period of examination expires ten (10) days after *you* apply for *your* policy and have received a copy of the policy. Failure to return the policy will be considered an acceptance of all of its terms, conditions and limitations. All other requests for termination are subject to the conditions provided for in the Statutory Conditions.
21. **Statutory Limitation** - every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act (BC, AB, MB, NS, PE – title of act may vary by jurisdiction), Limitations Act (SK, NF), Limitations Act, 2002 (ON) or other applicable legislation.
22. **Statutory Conditions** - despite any other provision of the policy, the policy is subject to the statutory conditions in the applicable insurance act respecting contracts of *accident* and sickness insurance of the Canadian province where the policy was issued.

STATUTORY CONDITIONS

Pursuant to the Accident and Sickness Insurance Act, the relevant statutory conditions which relate to individual health and travel insurance products have been provided below.

1. **The contract**

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

   Waiver

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

   Copy of application

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

2. **Material facts**

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

5. **Termination by insured**

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

6. **Termination by insurer**

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

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

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

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

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

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

7. **Notice and proof of claim**

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

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

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

   (ii) by delivery thereof to an authorized agent of the insurer in the province; not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability;

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

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

   Failure to give notice of proof

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

8. **Insurer to furnish forms for proof of claim**

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

9. **Rights of examination**

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

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

   (b) in the case of death of the person insured, the insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

10. **When moneys payable other than for loss of time**

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

DEFINITIONS

These apply to all insurance coverage and additional coverage purchased.

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

alteration: includes any newly prescribed medication, change in medication type or the increase, decrease or discontinuation of a medication and the adjustment (stop and start) in an anticoagulation medication dosage due to surgery within ten (10) days prior to *your effective date*, except:

a. a dosage adjustment for an anti-hypertensive or cholesterol lowering medication;
b. a change from a brand name medication to a generic brand medication of the same dosage;
c. if *you* are taking Coumadin/Warfarin for anticoagulation therapy and are required to have *your* blood levels tested on a regular basis (INR) and *your medical condition* remains unchanged, yet *you* are adjusting the dosage of *your* anticoagulation medication to ensure *your* INR is maintained within therapeutic range as directed by *your physician(s)*; or
d. if *you* are taking insulin or oral anti-diabetic medication for diabetes and are required to have *your* blood levels tested on a regular basis and *your medical condition* remains unchanged, yet *you* are adjusting the dosage of *your* medication to ensure *your* blood glucose level is maintained within therapeutic range as directed by *your physician(s)*.

application date: the date *you* apply and pay for *your* insurance policy.

common carrier: a conveyance (bus, taxi, train, boat, airplane or other vehicle), that is licensed, intended and used to transport paying passengers.

contracted: describes an agreement entered into where there is reference to a destination, a date and/or the time and place of arrival and/or departures for the *trip*.

deductible: the portion of eligible expenses *you* are responsible to pay out-of-pocket. *GMS* is only liable to pay sums in excess of this amount.

departure date: the day *you* leave *your province of residence*.

dependant(s): any unmarried child of *you* or *your spouse* (including step-child, adopted child or a child for whom *you* have been granted custody pursuant to an Order of the Court) who is chiefly dependent upon *you* or *your spouse* for support and maintenance, and is:

a. eighteen (18) years of age and under; or
b. twenty-four (24) years of age and under if the child is undergoing full-time student educational training in the same province as the *policyholder*; or
c. a developmentally or physically disabled child, regardless of age, if satisfactory proof of disability is received at time of application.

diagnosis: identification of *medical conditions*, illness or injury through investigation or analysis of the signs and symptoms.

effective date: means the date coverage starts as indicated in the section of this policy titled Coverage Starts and Ends for the specific plan purchased. For additional coverage or for coverage where it is not specified, the *effective date* is the date shown on *your* application.

expiry date: means the date coverage ends as indicated in the section of this policy titled Coverage Starts and Ends for the specific plan purchased. For additional coverage or for coverage where it is not specified, the *effective date* is the date shown on *your* application.

family member: *your* legal or common-law *spouse*, parent, brother, sister, legal guardian, step-parent, step-child, step-brother, step-sister, grandparent, grandchild, in-law or natural or adopted child.

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

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

government health plan: any insurance provided by or under the administrative control of any government or governmental agency in accordance with any law (other than The Employment Insurance Act of Canada) or any insurance coverage regulated by any government.

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 *medical treatment* of sick or injured persons on an in-patient basis, and, which has a laboratory, a registered graduate nurse and a *physician* always on duty and an operating room where surgical operations are performed by legally licensed medical *physicians*.

In no event shall the term "*hospital*" or "general active *medical 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 *medical treatment* centre for drug addiction or alcoholism.

medical condition(s): are any irregularities in *your* health:

a. for which *you* received *medical treatment* or *medical consultation*;
b. related to undiagnosed symptoms for which *you* received *medical treatment* or *medical consultation*; or
c. related to undiagnosed symptoms which would have caused an ordinary person to seek *medical treatment* or *medical consultation*.

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

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

medical treatment: any medical, therapeutic or diagnostic measure prescribed or recommended by a *physician* in any form, including: *prescription drugs*; investigative testing; in-*hospital* care; surgery; or other prescribed or recommended action directly referable to the applicable condition, symptom or problem.

physician: a duly qualified doctor of medicine entitled under the laws of the province, state or country where the services are rendered to practice medicine and surgery without restriction, but does not include a naturopath, herbalist or homeopath.

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

policy year: three hundred sixty-five (365) days following the *effective date* of the policy.

prescription drug: a licensed medicine that is regulated by legislation to require a prescription before it can be obtained. The term is used to distinguish it from over-the-counter drugs which can be obtained without a prescription. When referring to a prescription drug for a specified condition it includes but is not limited to those prescribed for the direct *medical treatment* of the diagnosed condition, the *medical treatment* of the symptoms associated with the diagnosed condition and the prevention of symptoms associated with the diagnosed condition.

province of residence: the province that *you* have declared as *your* permanent residence and *you* reside in for the required number of days outlined by *your* provincial health care legislation and/or *government health plan* in order to maintain *your* provincial health coverage.

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

return date: the date *you* are *contracted* to return to *your province of residence*.

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

stable: a *medical condition* is *stable* if, during the period of time specified in the policy, *you*:

a. have not received new *medical treatment*;
b. have not been prescribed a new *prescription drug*;
c. have not had a change in *medical treatment*;
d. have not had an *alteration* in a prescribed drug;
e. have not experienced a deterioration in *your* condition;
f. have not experienced new, more frequent or more severe symptoms;
g. have not had or required *medical consultation* to investigate symptoms that remain undiagnosed;
h. have not required in-*hospital* care or a referral to a specialist, including initial follow-up visits, tests or investigations related to the *medical condition* and pending results; and/or
i. do not anticipate further *medical treatment* after departure from *your province of residence*.

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

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

transportation: means economy class transport on a *common carrier* whether by land, air or sea.

travelling companion: is a person who is listed on *your* application or a person with whom *you* have pre-paid accommodations or *transportation* for the same *trip* and who will accompany *you* throughout the *trip*, to a maximum of four (4) persons including yourself.

trip: the entire period of travel *contracted* by *you*, and for which a premium was paid.

war: armed conflict, whether or not *war* has been declared, between nations or factions within a nation.

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

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