Benefits Booklet

RETIRE ALBERTA Est. 2014

Class A - Age 64 and under
Class B - Age 65 and over

GMS Plan #1023241

Effective: February 1, 2019
Revised: January 1, 2024

Policy Year: January 1- December 31

HEALTH & TRAVEL INSURANCE | GROUP BENEFITS

GMS

TABLE OF CONTENTS

Welcome

Group Medical Services (*GMS*) is pleased to provide you with this comprehensive extended health, dental and travel insurance benefits package.

The following booklet contains important information and should be kept in a safe place known to both you and your *family*. You are encouraged to read this book carefully so that you may fully understand the benefits available to you.

Should you require any information, please contact your Plan Administrator, or call *GMS* at 1.800.667.3699 or visit our website at www.gms.ca.

At Group Medical Services, we're looking after you and the ones you love.

Submitting Claims

How do I submit a claim to GMS?

In order for *GMS* to pay extended health or dental benefits, you need to submit a completed Health Benefits Claim Form for health or drug claims, Standard Dental Claim Form (obtained from the dental office) for dental claims, and the original receipts of the product or service you are claiming and the following information: *GMS* identification number, patient name, address and phone number, date and details of service and *physician* referrals where required.

Claim forms are available through your plan administrator or on the *GMS* website at www.gms.ca.

Please note that *GMS* does not return receipts so be sure to make copies of the receipts if you require them to co-ordinate claims with other carriers for income tax purposes. Claims must be submitted within twelve (12) months from the date of service in order to be eligible for reimbursement. However, if the *policy* terminates, *member*s must submit any claim(s) to Group Medical Services within thirty (30) days following the date of termination of the *policy*.

Claims can be mailed to:

Group Medical Services Claims Department
2055 Albert Street PO Box 1949
Regina, SK S4P 0E3

How do I use my Pay-Direct Card?

Your Pay-Direct Card contains your Group Medical Services identification numbers.

Simply present this card to participating pharmacies or dental service providers and claims will be submitted directly to *GMS* on your behalf, saving you time and money. Your provider will be able to tell you whether the product or service, or portion of that product or service, is eligible for coverage under your plan.

General Conditions & Exclusions

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.

Currency:

All amounts payable under this *policy* shall be payable in Canadian funds.

Duplicate Coverage With Other Plans:

After the benefits of the *government health plan*s have been determined, the excess benefits of this *policy* will be coordinated with those of other contracts or policies of the *insured person* who is covered for similar benefits simultaneously under any other contract or plan.

In the event that concurrent insurance from another source exists, benefits will be coordinated in accordance with the Canadian Life & Health Insurance Association guidelines.

The plan with no co-ordination of benefits provision in the contract or plan document determines benefits first. If the other plan(s) has a co-ordination of benefits provision, priority goes to the plan in the following order:

a. the plan where the *insured person* is covered as a *participant*;
b. if the *insured person* is a *participant* of two plans, priority goes to:
    i. the plan where the *insured person* is an active full-time *employee*;
    ii. the plan where the *insured person* is an active part-time *employee*;
    iii. the plan where the *insured person* is a retiree;
c. the plan where the *insured person* is covered as a *dependant spouse*;

Dependant Children

a. the plan of the parent with the earlier birthdate (month/day) in the calendar year;
b. the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate;
c. in situations where parents are separated/divorced, then the plan of the;
    i. parent with custody of the *child*;
    ii. *spouse* of the parent with custody of the *child*;
    iii. parent not having custody of the *child*; or
    iv. *spouse* of the parent not having custody of the *child*.

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

Legislation requires the *policyholder* to follow the RAMQ (Regie de l'assurance maladie du Quebec) reimbursement guidelines for all residents of Quebec.

Co-ordination with Publicly Funded Programs:

When requested by *GMS*, the insured person must apply for all publicly funded support programs that exist or may come to exist during the *policy* year.

Individual Certificate and Manuals:

GMS will issue to the *policyholder* for delivery to each *participant* covered, an individual certificate setting forth the benefits to which the *insured person*(s) are entitled, to whom coverage is payable, and containing any and all provisions regarding the termination or reduction of the *insured person*'s coverage.

The individual certificate or other *policy* description shall not constitute a part of this *policy*. In the event of a discrepancy between individual certificate provisions and those of this *policy*, the provisions of this *policy* will prevail.

Participation:

A *member* and a spouse who are members of Retire Alberta must enrol as a *family* and not as *single participants*.

Members Eligible for Coverage:

In order to be eligible for coverage under this *policy*, *member*s (herein after "Members") must maintain membership in good standing with Retire Alberta. *Members* must have valid health coverage from their province of residence. *Members* must be retired employees from the Province of Alberta, or the Alberta public sector.

Benefit eligibility is contingent upon full payment of all required premiums.

Effective Date of Coverage for Members:

A *member* must apply for coverage within sixty (60) days following the date of retirement or loss of other coverage, such as individual or spousal coverage. The effective date shall be the first of the month following the date of retirement/loss of coverage. If a *member* does not apply for coverage within sixty (60) days of becoming eligible, their effective date shall be the first of the month following the date that a completed medical questionnaire has been received and accepted at the office of *GMS*. Please see the respective *Late Applicant* conditions.

Termination of a Member's Coverage:

The coverage of a *member* under this *policy* terminates automatically on the earliest of the following dates:

a. the date of termination of this *policy*;
b. the end of the period for which required premiums have been paid; or
c. the date on which the person ceases to satisfy the definition of a *member* as provided in this *policy.*

Dependants Eligible for Coverage:

A *participant*'s *dependant* shall be eligible for coverage on the latest of the following dates:

a. the date that the *participant* becomes eligible for coverage under this *policy*; or
b. the date that the individual becomes a *dependant* as defined in this *policy*.

In order to be eligible for coverage under this *policy*, the *dependant* must have valid health coverage from their *province of residence*.

Notice of *dependant* eligibility shall be provided in writing to *GMS*.

GENERAL CONDITIONS & EXCLUSIONS

Effective Date of Coverage for Dependants:

The coverage of an eligible *dependant* of an eligible *participant* becomes effective on the latest of:

a. the date the *participant*'s coverage becomes effective;
b. the date the *dependant* first meets the eligibility requirements.

The coverage of any *dependant* for which the *participant* makes a written request more than thirty (30) days from the date the *dependant* was first eligible shall become effective only if and when *GMS* gives its written consent.

The coverage of a *dependant* newborn is effective on their date of birth if *GMS* is notified within thirty (30) days of their birth.

No *dependant* of a *member* shall become covered under this *policy* if the *member* is not simultaneously covered under this *policy*.

Termination of Dependant's Coverage:

Coverage of a *dependant* under this *policy* terminates automatically on the earliest of the following dates:

a. the date of termination of this *policy*;
b. the end of the period for which required premiums for *dependant* coverage, on behalf of the *participant*, have been paid;
c. the date that the person ceases to satisfy the definition of a "*dependant*";
d. the date of termination of the coverage of the *participant* of which the person is *dependant*.

Survivor Benefit:

In the event of death of the *participant*, *GMS* will continue the Extended Health and Travel benefits and/or Dental benefits without payment of premium for the *dependant*(s) until the earliest of:

a. the date the *dependant* is no longer deemed a *dependant* as defined in this *policy*;
b. the date similar coverage is obtained elsewhere;
c. the date which is three (3) months after the death of the *participant*; or
d. the date the group *policy* terminates.

Late Applicant:

At the time the *member* or *dependant(s)* becomes eligible for coverage, they have sixty (60) days to apply for coverage. If coverage is not applied for within that time frame the following restriction apply:

a. the *member* will be required to complete a medical questionnaire and health coverage shall be contingent upon approval by *GMS*; and

all dental benefits shall not exceed $250 during the first twelve (12) months of coverage.

Date Incurred:

Expenses are deemed to have been incurred on the date the service was rendered or the supply was delivered. Expenses incurred prior to the effective date of this *policy* are not eligible for coverage.

Right to Recover:

GMS shall be entitled to a refund of the amount of any benefits paid under this *policy* in respect to services and supplies not paid for by the *participant* or *dependant*, or for which the *participant* or *dependant* was reimbursed otherwise than under this *policy*.

Whenever payments have been made by *GMS* in excess of the maximum amount of benefit necessary to satisfy the *policy*, *GMS* shall have the right to recover such excess payments from the persons insured by the *policy*, the *policyholder* or any other insurance companies, underwriters or administrators of similar benefit plans.

Upon making any payment under this *policy*, *GMS* shall be subrogated to all of the rights of recovery against any third party at fault for the loss and may bring action in the name of the *insured person* or *policyholder* (as applicable) to recover these payments. The *insured person* or *policyholder* agrees to fully cooperate with or assist *GMS* in respect of any subrogated claim made pursuant in this section.

If *GMS* determines that there is no coverage for a claim(s) under this *policy*, notwithstanding that amounts may have been advanced to the *insured person* or on their behalf, all amounts so advanced to them or on their behalf must be repaid by the *insured person* to *GMS* on demand. In such circumstances any payment(s) made by *GMS* will not constitute an acceptance of coverage.

Furnishing of Information: Access to Records and Privacy:

Minor, non-material clerical errors on the part of the *policyholder* shall not prejudice the coverage of any *insured person*.

GMS may release to, or obtain from, any other company or administrator of benefit plans, any information with respect to any person which *GMS* requires to administer claims or co-ordinate benefits under this *policy*. Any person claiming benefits under this *policy* shall furnish such required information.

The *policyholder* will permit *GMS* to inspect records of the *policyholder* as may be necessary to verify information and particulars during the continuance of, and within one (1) year after the final expiration of this *policy*.

GMS and the *policyholder* each agree to comply with their respective obligations pursuant to the *Personal Information Protection and Electronic Documents Act*, as amended or replaced from time to time, or other similar data protection laws, as applicable.

GMS may, for the purposes of administering any benefits, products, or services to be provided pursuant to this *policy* and determining eligibility for benefits:

a. when the *participant* authorizes 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 their medical history, symptoms, *medical treatment*, examination, *diagnosis* and/or services rendered to the *participant* and or their *dependant*s;
b. collect, store and use any personal information about any *insured person* which the *insured person* or *policyholder* has provided to *GMS* or any personal information which *GMS* has obtained pursuant to clause (c) below;
c. obtain personal information about any *insured person* from, or disclose such personal information to: any *government health plan*; the operator of any *hospital*, clinic, or other health facility; a doctor or other health care provider; any insurance company; or any other service provider or third party as may be reasonably required for the purposes described in (b).
d. acknowledging, subject to legal or contractual restrictions, the *participant* may (upon reasonable written notice to *GMS*), choose to withdraw their consent to the collection, use and disclosure of such information. If *participant* consent is withdrawn, the *participant* will restrict *GMS*' ability to administer this *policy*. Further, if the participant withdraws their consent, *GMS* may not be able to offer the participant *GMS* products and services and the *participant* will limit *GMS*' ability to pay their claim(s).

With respect to any personal information about any *insured person* provided to *GMS* by the *policyholder*, the *policyholder* hereby represents and warrants to *GMS* that the *policyholder* has obtained the consent of the *insured person* to such disclosure.

With respect to any personal information about a *dependant* provided to *GMS* by any *participant*, the *participant* hereby represents and warrants to *GMS* that he/she has obtained the consent of the *dependant* to such disclosure.

The foregoing provisions which authorize the collection, use and disclosure of personal information by *GMS* are intended to supplement, and not replace, the *GMS* privacy policy and any specific authorizations provided to *GMS* in connection with the administration of this *policy*.

Payment of Claims:

GMS may pay benefits under this *policy* to the *insured person* who incurred the expense for themselves or their covered *dependant*(s), or in some situations *GMS* may pay part or all of the benefit directly to the provider of the service.

When requested by *GMS,* the *insured person* must apply for all publicly funded support programs that exist or may come to exist during the *policy year*.

In order for *GMS* to assess health benefits, a completed Group Medical Services Health Benefits Claim Form must be submitted with original itemized receipts, including name, date and details of service, and *physician* referrals where required.

In order for *GMS* to assess travel benefits, please refer to *Making a Medical Emergency Claim.*

In order for *GMS* to assess manually submitted dental claims, a standard dental claim form obtained from the dental office must be submitted.

As a condition precedent to recovery of insurance monies under this contract. The claimant shall afford to *GMS* an opportunity to examine the *insured person* when and so often as *GMS* reasonably required while the claim hereunder is pending.

All monies payable under this *policy*, other than benefits for loss of time, shall be paid by the insurer within sixty (60) days after satisfactory proof of claim has been received and accepted by *GMS*.

Benefits payable shall not include interest charges.

Submit claims to: Group Medical Services Claims Department
2055 Albert Street PO Box 1949
Regina, SK S4P 0E3

GENERAL EXCLUSIONS

Risky Activities:

GMS does not cover any expenses resulting from the *insured person's* participation in:

a. professional sport;
b. speed contests or racing;
c. an extreme sport, including but not limited to, scuba diving (except when the *insured person* is NAUI, PADI, ACUC or SSI certified), bungee jumping, parachuting, mountaineering, skydiving, rodeo, hang gliding, acrobatic or stunt flying.

Non-Common Carrier Air Travel:

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

Work:

GMS does not cover any expenses for work related *accident*s.

Risky Work or Volunteer Activities:

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

Result of Conflict:

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

Self-harm:

GMS does not cover any expenses resulting from suicide or self-inflicted injuries.

Criminal or Illegal Activity:

GMS does not cover any expenses resulting directly or indirectly from the *insured person's* criminal or illegal acts.

Drugs & Alcohol:

GMS does not cover any expenses resulting from the *insured person's* 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.

Motor Vehicle Accident:

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

GENERAL CONDITIONS & EXCLUSIONS

General:

Benefits are payable only for amounts in excess of what would normally be payable under *government health plan*s as they exist as of the *policy* effective date of this *policy*. There is no coverage for any benefits of any nature, which were provided by a *government health plan* on the *policy* effective date of this *policy* regardless of whether such benefits continue to be provided by a *government health plan* at the time a claim is made.

Any material misrepresentation, provision of incorrect information or non-disclosure of information by the *insured person* will result in non-payment of any claim and will void the *insured person*'s coverage.

GMS is not responsible for the availability, quality, results or effectiveness of any *medical treatment* or *transportation* or the *insured person*'s failure to obtain *medical treatment*.

No payment will be provided for expenses not deemed medically necessary.

EXTENDED HEALTH BENEFITS SUMMARY

IN CANADA HEALTH BENEFITS ARE PAYABLE TO A COMBINED MAXIMUM OF $10,000 PER PERSON PER POLICY YEAR.

Unless indicated otherwise, the following Extended Health and Travel Benefits Summary apply to Class A and Class B *members*. In order for goods purchased to be eligible for reimbursement, they must be purchased within Canada and will be paid based on *reasonable and customary* charges within the *member's province of residence*.

In Province/Territory Health Benefits	Percent Eligible	Per Insured Person, per Policy Year (unless stated otherwise)
Prescription Drug	80%	$1,500
Vison	100%	$300 per two (2) *policy years*
Eye Exams	100%	One (1) exam per two (2) *policy years*
Road Ambulance	100% Return Trips 50%	Unlimited
Air Ambulance	100%	$4,000
Private Duty Nursing	100%	$2,500
Preferred Hospital Room	100%	Unlimited
Accidental Injury to Natural Teeth	100%	$2,000 per injury
Health Practitioners	100%	$400 per specialty per person per *policy* year maximum of $60 per visit for: acupuncture, chiropractic *treatment*, massage therapy, speech therapy, osteopathic *treatment,* chiropodist/podiatry and physiotherapy/athletic therapy maximum of $75 per visit for: clinical psychology and naturopathic *treatment*
Casts and Crutches	100%	Unlimited
Patient Walkers	100%	$200 per family per three (3) *policy* years

Artificial Eyes, Limbs and Larynx	100%	Lifetime maximum of $10,000
Private Duty Nursing	100%	$2,500
Preferred Hospital Room	100%	Unlimited
Wheelchairs and Motorized Scooters	100%	$500 per family per five (5) *policy* years
Adjustable Beds	100%	$500 per family per five (5) *policy* years
Diabetic Supplies and Equipment	100%	$300 Blood Glucose Monitors – one (1) per four (4) *policy* years
Ostomy Supplies	100%	$300
Oxygen Equipment	100%	$500
Breast Prosthesis	100%	One (1) per two (2) *policy* years for lateral or Two (2) per two (2) *policy* years for bilateral
Custom Made Foot Orthotics	100%	$300 per two (2) *policy* years
Therapeutic Shoes	100%	$200
Hearing Aids	100%	$500 per three (3) *policy* years
Out of Province/Territory Referral	100%	Lifetime maximum of $50,000
Health Supplies and Equipment	100%	$500 combined maximum With the following exception for embolic (compression) stockings – four (4) pairs per *policy* year

Health Benefits

Prescription Drugs: Payment for the expenses of *formulary* and non-*formulary* drugs when ordered in writing by a *physician*, *dentist* or optometrist.

If brand name prescription drugs are dispensed, payment will be made up to the cost of the generic substitution. *GMS* will only provide payment for the cost of brand name prescription drugs if “no substitutions” is specifically indicated on the prescription by the *physician*. To ensure *the insured person*’s prescription is eligible for coverage, the *insured person* should consult their pharmacist as some drugs may require *GMS* approval prior to the prescription being filled.

This benefit excludes the following prescription drugs: fertility drugs; drugs intended for the *treatment* of sexual dysfunction; lifestyle drugs; drugs intended for the *treatment* of hair loss or to restore hair growth;

experimental drugs; diet drugs; drugs used for cosmetic purposes; over-the-counter drugs; drugs used to stop smoking; vitamin products; blood and blood plasma; foams or gels; atomizers; vaporizers; first aid supplies; food and nutritional systems. This benefit also excludes delivery and *transportation* charges; and video instructional kits, information manuals or pamphlets.

All claims for prescription drugs whether by pay-direct drug card or by manual submission, must first be submitted to the *insured person*'s provincial drug plan for eligibility. In order to ensure proper coordination with the *insured person*'s provincial health plan, the *insured person*, when requested by *GMS* must apply for all publically funded support programs that exist or may come to exist during the *policy year*. *GMS*' coverage applies after the benefits of the *government health plan*s, including but not necessarily limited to the provincial drug plan, have been determined.

Vision:
Eye Exams
Provides payment for an eye exam, by a qualified physician, optometrist, or ophthalmologist, to measure the visual acuity of the patient
Lens/Frames/Contacts
Provides payment for prescription lenses, frames, contact lenses, and/or refractive laser eye surgery.

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 out-patient treatment.
50% of the cost of ambulance transportation returning the insured person to their place of permanent residence will be paid if the insured person is bedridden upon discharge from hospital. Air Ambulance: Within the insured person's province of residence, payment for emergency transport by a licensed professional air ambulance to the nearest hospital or health centre equipped to provide the necessary emergency treatment, when authorized by a physician.

Private Duty Nursing: Payment of in-*hospital* or in-*home* duty private duty nursing costs when ordered in writing by the attending *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, who is not *immediately related* to the *insured person* or who does not ordinarily reside in the *insured person*'s *home*.

The *benefit effective date* must precede the *hospital* admittance date.

Preferred Hospital Room: Reimbursement of private or semi-private *hospital* room costs. The *benefit effective date* must precede the *hospital* admittance date.

This benefit excludes stays for convalescent and respite care.

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

This benefit excludes dental implants.

Health Practitioners: Provides payment for the stated services under the schedule of benefits. All services must be provided by a practitioner who is licensed, certified, or registered by their provincial regulatory agency, or a registered member of a professional association recognized by GMS.

Casts and Crutches: Payment of the costs for fiberglass casts and for the purchase or rental of crutches.

Patient Walkers: Payment for the purchase or rental of patient walkers, when ordered in writing by a *physician*.

Artificial Eyes, Limbs and Larynx: Payment of the purchase of artificial eyes, limbs and/or larynx.

This benefit excludes myoelectric limbs.

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.
This benefit does not cover hospital beds for individuals confined to, or resident in an active hospital, convalescent facility, nursing home, extended care facility, rehabilitation center, rest home or personal care home. Must submit an estimation for review before purchase.

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

This benefit excludes insulin pumps, insulin and other *prescription medication*s.

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

Oxygen: Payment for the purchase and/or rental cost of oxygen equipment and/or Continuous Positive Airway Pressure (CPAP) machines or supplies when ordered in writing by a physician for personal use in the home.

This benefit excludes the cost of oxygen.

Breast Prosthesis: Payment for the purchase of an artificial breast prosthesis.

This benefit excludes surgical brassieres.

Custom Made Foot Orthotics: Payment for the purchase of custom made foot orthotics. Made at an accredited podiatric biomechanics laboratory and created by using a three-dimensional impressing technique or a three-dimensional model of the foot and be made from raw materials. Three-dimensional impressing techniques include foam box impression, plaster casting and direct mould and supplied by a certified pedorthist, certified orthotist or chiropodist/podiatrist.

This benefit excludes payment for the costs of assessment, casting or scanning.

Therapeutic Shoes: Payment for the permanent modification or repair or replacement of customized therapeutic shoes. A written prescription, including a medical *diagnosis*, is required from an orthopaedic *surgeon*, podiatrist, pedorthist, orthotist, chiropodist or an attending *physician*. The shoe must be custom built, specifically designed or melded, or permanently modified for the *insured person*, and supplied by a certified pedorthist, orthotist or chiropodist/podiatrist. The receipt must be completely itemized, with the type of shoe including all modifications done.

This benefit excludes payment for sandals, runners, boots or any shoes that have pointed toes.

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

Out of Province Referral: Payment for *physician*, anaesthetic, radiology, laboratory, *hospital* and ambulance services outside of the *insured person*'s *province of residence*, for *treatment* which is not available in the *insured person*'s *province of residence*, when recommended in writing by a specialist *physician*. The claim must have prior written approval from *GMS*. *GMS* will not approve payment for *treatment* where there are government funded *treatment* options available in the *insured person*'s *province of residence*. Payment will not be made for *treatment* related to any condition, disease or illness that existed in the twelve (12) months prior to the effective date of coverage.

This benefit excludes referrals for *treatment* outside of Canada.

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

Extended Health Benefits Conditions & Exclusions

The following conditions and exclusions apply to the Health Benefits:
3.1 Health benefits are available within Canada.

3.2 Services totalling $500 or more must have prior approval from GMS before the services are begun. If a health pre-authorization is not submitted prior to commencement of services, benefits otherwise payable, may be limited to $500 for the services performed.

3.3 GMS will pay for services and procedures only to the maximum amounts as provided for in our schedule of benefits while applying reasonable & customary (r&c) amounts. Any charges over and above the benefit maximum and/or the r&c will be the insured person's responsibility.

3.4 The following services or supplies are excluded from coverage:

3.1 expenses compensable under Worker's Compensation Laws or any Government Agency;

3.2 expenses for cosmetic purposes;

3.3 Expenses for diagnostic or investigative testing;

3.4 Expenses from services provided by family members;

3.5 Expenses for examinations related to surgical procedures;

3.6 Expenses for post-surgical lenses;

3.7 Expenses relating to non-prescription eyeglasses or sunglasses;

3.8 Expenses when no transport occurs or for transportation to or from physicians' offices, laboratories, and medical clinics.

TRAVEL BENEFITS SUMMARY

Out of Province or Canada Travel Benefits	Percent Eligible	Per Insured Person, per Policy Year (unless stated otherwise)
Travel Coverage	100%	$2,000,000
In-Hospital-Care	100%	
Medical Services	100%	
Diagnostic Services	100%	
Out-Patient Medical Treatment	100%	
Prescription Medication	100%	Maximum thirty (30) day supply
Rental of Essential Medical Appliances	100%	
Emergency Dental Services	100%	$2,000 Relief of dental pain $250
Private Duty Nursing	100%	$5,000
Health Practitioners	100%	Combined maximum of $300
Road Ambulance	100%	
Remote Evacuation	100%	$5,000
Repatriation	100%	
Special Attendant	100%	
Return of Family Member	100%	$1,000
Return & Escort of a Dependent Child	100%	
Family / Friend to Bedside	100%	Airfare $3,000 Expenses $150 per day to maximum of $750 per *policy* year
In Event of Death	100%	Airfare $2,000 Including for meals & accommodation $300
Return of Remains	100%	$3,000 for preparation and *transportation* or $2,000 for cremation or burial
Return of Vehicle	100%	$2,000 per *policy* per trip

Return of Cat or Dog	100%	$300 per incident
Child Care	100%	$500 per *policy* per trip
Out-of Pocket Expenses	100%	Up to $150 per day to a maximum of $1,000
Coverage Continuation		72 Hours
24-Hour Travel Assistance Services		For medical emergencies and assistance, contact GMS 24-Hours a day, 7 days a week: Toll Free: 1.800.459.6604 (within Canada & US) Collect: 905.762.5196 (from all other locations)

Travel Benefits

Group Medical Services (*GMS*) will pay the *reasonable and customary* charges up to a maximum amount payable of $2,000,000 of eligible expenses in the event that an unexpected *medical emergency* occurs outside of the *insured person*'s *province of residence* or Canada. Payment will only be made in excess of any deductibles and any amounts covered by your provincial *government health plan* or other insurance plan(s).

For expenses to be eligible for reimbursement under this *policy*, the emergency *treatment* for a sudden or unexpected illness or *accidental* injury and the necessary *diagnosis* and *treatment* must occur within the first one hundred and eighty-three (183) days after leaving the *insured person*'s *province of residence* if travelling within Canada, or within the first ninety (90) days after leaving Canada.

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.

Medical Services: Expenses for *medical treatment* from a *physician*.

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.

Out-Patient Medical Treatment: Expenses for out-patient emergency *medical treatment*.

***Prescription Medication*:** Expenses for *prescription medication*s 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 medication*s that are lost, stolen or damaged during the *insured person*'s trip are covered up to a maximum of $50 per prescription. *Physician*'s expenses related to replacement are not covered.

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 the *insured person*'s trip. The rental expense must not exceed the cost to purchase the appliances.

Pre-approval by *GMS* is required.

Emergency Dental Services: Expenses for emergency services due to an *accidental* blow to the mouth that requires the repair or replacement of natural teeth or permanently attached artificial teeth.

Expenses for the *treatment* or the relief of dental pain for any dental emergency other than that caused by an *accidental* blow to the mouth.

Private Duty Nursing: Expenses 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.

Health Practitioners: Expenses for the services of an osteopath, physiotherapist, chiropractor, chiropodist, or podiatrist.

Road Ambulance: Expenses for the use of a licensed road ambulance in a *medical emergency* where the *insured person* requires immediate transport to the nearest *hospital* with adequate facilities.

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.

Repatriation: Expenses to transport the *insured person* by air ambulance (excluding helicopters) or regularly scheduled common carrier back to their *province 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.

Pre-approval by *GMS* is required.

Special Attendant: Expense of round-trip *transportation* for the transport of a medical attendant to accompany the *insured person* back to their *province 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.

Return of Family Member: Expenses for one-way air *transportation* to return one (1) accompanying *family* member insured under the *participant*'s benefit plan to their *province of residence* when:

a. *GMS* requires that the *insured person* returns to their *province of residence* for further in-*hospital medical treatment*; or
b. in the event of the *insured person*'s death.

Pre-approval by *GMS* is required.

Return & Escort of a Dependent Child: Expense of one-way *transportation* to return the *insured person*'s dependent children travelling with them, who are under the age of eighteen (18) to the *insured person*'s *province of residence* when the *insured person* has been returned to their *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.

Family/Friend to Bedside: Expenses for round-trip air *transportation* for a *family* member or a close friend to visit the *insured person* 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.

TRAVEL BENEFITS

GMS will reimburse for the expenses incurred by the *family* member or close friend while the *insured person* is hospitalized.

Original receipts must be submitted to be eligible for reimbursement.

In Event of Death: Expenses for round-trip air *transportation* to provide for the return of a *family* member who is 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 for meals and accommodations incurred during travel.

Pre-approval by *GMS* is required.

Return of Remains: Expenses for the preparation and transport of the *insured person*'s remains to their *province of residence*, or cremation or burial at the place of death, when the *insured person*'s death was a result of a *medical emergency*.

This benefit does not cover the cost of a burial casket or urn.

Return of Vehicle: Expenses to return the *insured person's* vehicle to their *province of residence*, or a vehicle rented by the *insured person* to the nearest rental agency, when the *insured person* or any *travelling companion*s are unable to do so because the *insured person* has been returned to their *province 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.

Pre-approval by *GMS* is required.

Return of Cat or Dog: Expenses to return the *insured person*'s cat or dog to their *province of residence*, when the *insured person* has been returned to their *province of residence* for further in-*hospital medical treatment*.

Child Care: Expenses for licensed care of dependent children or mental or physically challenged persons, who rely on the *insured person* for assistance, if they are travelling with the *insured person*, should the *insured person* require in-*hospital* care.

Pre-approval by *GMS* is required.

Out-of-Pocket Expenses: Expenses incurred by a *travelling companion* insured under the *insured person*'s *policy* in the event the *insured person* is in *hospital* receiving care on their *return date*. This benefit includes coverage for accommodations, which shall form part of the benefit limit.

Pre-approval by *GMS* is required.

Coverage Continuation: If coverage expires while hospitalized due to an emergency, applicable coverage will continue for the *insured person* and any insured *dependant*s travelling with the *insured person*, for up to seventy-two (72) hours after the *insured person* is discharged from the *hospital*.

24-Hour Travel Assistance Services:

a. co-ordination of all medical care, *transportation*, and repatriation
b. telephone interpretation services in most languages; and
   monitor progress during *treatment* and recovery by managed care.

Travel Benefits Conditions & Exclusions

In addition to the General Conditions and Exclusion, the following provisions apply to travel outside of the *insured person*'s *province of residence* and Canada.

CONDITIONS

GMS, in consultation with the attending *physician*, reserves the right to transfer the *insured person* to another *hospital* or medical facility or to return the *insured person* to their *province of residence* if deemed medically necessary.

Benefits are payable in accordance with the benefits listed in this *policy* and limited to the sum insured.

GMS reserves the right to negotiate amounts payable on *the insured person's* 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.

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.

In the event *the insured person* 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 when retirement group health coverage exists with a lifetime limit of $50,000 or less.

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.

EXCLUSIONS

Stability:

For *insured person* under the age of seventy-five (75) *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 the *insured person's departure date* including:

a. *medical condition*(s) for which the *insured person* received *medical treatment* or *medical consultation*; and/or
b. undiagnosed *medical condition*(s) related to symptoms for which the *insured person* received *medical treatment* or *medical consultation.*

For *insured person* over the age of seventy-five (75) *GMS* does not cover any expenses resulting from *medical condition*(s) which have not been *stable* for three hundred and sixty-five (365) days immediately prior to the *insured person's departure date* including:

a. *medical condition*(s) for which the *insured person* received *medical treatment* or *medical consultation*; and/or
b. undiagnosed *medical condition*(s) related to symptoms for which the *insured person* received *medical treatment* or *medical consultation.*

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

Recurrence of a Medical Condition:

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

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*.

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*.

Delay-able Treatment:

GMS does not cover any expenses for *medical treatment* that can be reasonably delayed until the *insured person* returns to the *insured person's province of residence*.

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 *the insured person's medical treatment* provided at *the insured person's* trip destination.

Refusal of Transfer:

GMS does not cover any expenses following the *insured person's* refusal to transfer to another *hospital* or medical facility capable of providing necessary *medical treatment*, or the *insured person's* refusal to return to the *insured person's province of residence* when deemed medically necessary. Refusal to comply with a transfer request or a request to return to *the insured person's province of residence*, when *the insured person* could have been returned to *the insured person's province of residence* without endangering the *insured person's* life or health, even if the *treatment* available in the *insured person's province of residence* could be of lesser quality than the *treatment* available outside the *insured person's province of residence* or the *insured person* 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.

Refusal to Follow Medical Advice or Advice of GMS:

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

Non-Adherence:

GMS does not cover any expenses that result from the *insured person's* 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.

Acting Against Physician's Advice:

GMS does not cover any expenses when the *insured person* travels against the advice of a *physician*.

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.

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*.

Certain Pre-Existing Conditions:

GMS does not cover any expenses related to a pre-existing *diagnosis* that is emotional, psychological or psychiatric in nature.

Travel Advisory:

GMS does not cover expenses arising where:

a. Before your *departure date*, an official travel advisory is issued by the Canadian government, stating "Avoid non-essential travel" or "Avoid all travel" for the country, region, city or other destination, (including cruise ship) that are part of your travel arrangements.
b. This exclusion does not apply when the "Avoid non-essential travel" warning is in place exclusively due to COVID-19.

To view the travel advisories, visit the Government of Canada Travel site (https://travel.gc.ca/travelling/advisories)

Failure to Obtain GMS Pre-Approval:

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

Unapproved Treatment:

GMS does not cover any expenses for *medical treatment* or services that contravene or are prohibited by the provincial laws of the *insured person's province of residence* or the federal laws of Canada.

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 the *insured person's* departure, however caused.

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

In the event of a *medical emergency*:

You must contact *GMS Travel Assistance* where possible before *the insured person* seek *medical treatment*. *GMS Travel Assistance* will:

a. offer telephone interpretation services in many languages;
b. monitor progress during *the insured person's medical consultation* and *medical treatment*; and
c. coordinate all *medical treatment*, transport, and repatriation.

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 Medical Emergency 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 *the insured person* or any other benefit plan;
3. complete medical records including final *diagnosis* by the attending *physician*;
4. proof of travel showing the date *the insured person* departed from and returned to *the insured person's province of residence*;
5. *the insured person's* 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 *the insured person's* 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 *the insured person's* claim are not covered.

DENTAL BENEFITS SUMMARY

Included below is a list of dental benefits available in Canada.

The following Dental Benefit Summary apply to Class A and Class B *members*.

Eligible preventative, basic and major dental expenses are payable to a combined maximum of $1,250 per person per *policy year*.

GENERAL PROVISIONS

The eligible services listed below are not an attempt to dictate dental health requirements. The *insured person*'s *dentist* is best able to determine the dental *treatment* program, although those services may not be eligible under this plan.

Preventative Dental Services	Percent Eligible	Per Insured Person, per Policy Year (unless stated otherwise)
Preventative Dental Services: a. scaling, b. periodontal root planing, c. polishing, d. application of sodium or topical fluoride *treatment*.	80%	Based on *units* of 15 minutes a. Six (6) *units* combined with root planing b. Six (6) *units* combined with scaling c. Two (2) *units* d. Two (2) *units*
Pit and fissure sealants	80%	One (1) per tooth per lifetime for *dependant*s under the age of eighteen (18) years
Space Maintainers	80%	
Occlusal Adjustment and Equilibration	80%	Four (4) *units* combined
Protective Mouth Guard Appliances	80%	One (1) per *policy year* for *dependant*s under sixteen (16) years of age, and one (1) per three (3) *policy year*s for the *insured person* sixteen (16) years of age and over
Interproximal Disking of Teeth	80%	
Dental Appliances	80%	One (1) per *policy year* for *dependant*s under sixteen (16) years of age, and one (1) per three (3) *policy year*s for persons over 16 years of age
Basic Dental Services	**Percent Eligible**	**Per Insured Person, per Policy Year (unless stated otherwise)**
Complete Dental Examinations	80%	Once per three (3) *policy year*s
Limited oral examination: a. recall and specific examinations b. emergency examinations	80%	a. Nine (9) month recall. Subject to a combined maximum of two (2) examinations per *policy year* b. Unlimited

Dental x-rays (radiographs)**:** a. complete (full mouth) or panoramic series, b. Intra-oral or Extra-oral	80%	a. One of either type per three (3) *policy year*s b. Ten (10) films per two (2) *policy year*s
Treatment Planning and Consultations	80%	
Basic Oral Surgery	80%	
Basic Restorations of Teeth	80%	
Endodontic *Treatment* for Permanent Teeth	80%	Root canal therapy is limited to one (1) per tooth per five (5) *policy year*s
Endodontic Re-*treatment*	80%	Limited to one (1) per tooth per five (5) *policy year*s
Diagnostic Casts	80%	Once per three (3) *policy year*s
Anaesthesia	80%	
Non-Surgical and Surgical Periodontal Services	80%	Each type of surgery is limited to one (1) per site (sextant)
Rebasing and Relining of Dentures	80%	Once per three (3) *policy year*s
Removable prosthodontic services	80%	
Fixed prosthodontic repairs	80%	
Major Dental Services	**Percent Eligible**	**Per Insured Person, per Policy Year (unless stated otherwise)**
Complete and/or Partial Dentures	50%	One (1) per arch.
Replacement of Complete and/or Partial Upper and Lower Dentures	50%	Replacement of complete or partial dentures provided the existing complete or partial denture is at least five (5) years old. The cost of transitional dental work will be deducted from the final bridge or denture, if done within one (1) year.
Inlays, Onlays, Crowns, Veneers	50%	Replacements must be separated by at least five (5) years.
Denture Adjustments	50%	Once per *policy year*
Initial Bridge Pontics and Fixed Bridge Retainers	50%	
Replacement Bridge Pontics and Fixed Bridge Retainers	50%	Replacements must be separated by at least five (5) years

Dental Benefits

Preventative Dental Services: Expenses for preventative dental services including scaling, periodontal root planing, polishing and application of sodium or topical fluoride *treatment*.

Pit and Fissure Sealants: Expenses for pit and fissure sealants one (1) per tooth per lifetime for *dependant*s under the age of eighteen (18) years.

Space Maintainers: Expenses for space maintainers and maintenance when a *dentist* has removed a primary tooth and an appliance is used to maintain space for a permanent tooth.

Occlusal Adjustment and Equilibration: Expense for occlusal adjustment and equilibration to a maximum of four (4) *units* combined.

Protective Mouth Guard Appliances: Expenses for protective mouth guard appliances to a maximum of one (1) per *policy year* for *dependant*s under sixteen (16) years of age, and one (1) per three (3) *policy year*s for the *insured person* sixteen (16) years of age and over.

Interproximal Disking of Teeth: Expenses for interproximal disking of teeth.

Dental Appliances: Expenses of dental appliances for the control of oral habits including bruxism.

Complete Dental Examination: Expenses for complete dental examination which would include history, medical and dental; clinical examination and *diagnosis*.

Limited Oral Examination: Expenses for limited oral examination including recall, specific and emergency examinations.

Dental X-Rays: Expenses for dental x-rays (radiographs) including a complete (full mouth) or panoramic series and intra-oral and extra-oral.

Treatment Planning and Consultations: Expenses for *treatment* planning and consultation when provided by a *dentist*.

Basic Oral Surgery: Expenses for basic oral surgery including erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions, and postsurgical care.

Basic Restorations of Teeth: Expenses for basic restorations of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations and composite restorations.

Endodontic Treatment*:* Expenses for endodontic *treatment* for permanent teeth including *treatment* of the pulp chamber, root canal therapy, periodical services, miscellaneous surgical services (root amputation, hemisection, replantation, and perforations), and miscellaneous endodontic procedures (open and drain and non-vital bleaching).

Endodontic Re-Treatment: Expenses for the endodontic re-treatment of a previous root canal.

Diagnostic Casts: Expenses for diagnostic casts once per three (3) *policy year*s, including the current *policy year.*

Anaesthesia: Expenses for anaesthesia occurred during a dental treatment**.**

Non-Surgical Periodontal Services: Expenses for non-surgical periodontal services including management of oral disease and desensitization.

Surgical Periodontal Services: Expenses for surgical periodontal services including gingival, curettage, gingivoplasty, gingivectomy and flap approach.

Rebasing and Relining of Dentures: Expenses for rebasing and relining of dentures once per person per three (3) *policy year*s including the current *policy* year.

Removable Prosthodontic Services: Expenses for removable prosthodontic services including denture repairs and additions, tissue conditioning for dentures and miscellaneous denture services (resilient liner and resetting of teeth).

Fixed Prosthodontic Repairs: Expenses for fixed prosthodontic repairs including the replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, recementation, and fixed bridge/ prosthesis repairs.

Compete and/or Partial Dentures: Expenses for initial complete or partial dentures. Services are limited to teeth extracted insured under this *policy* to a maximum of one (1) per arch.

Replacement of Complete and/or Partial Upper and Lower Dentures: Expenses for the replacement of complete and/or partial upper and lower dentures. Services are limited to teeth extracted while insured under this *policy*. The cost of transitional dental work will be deducted from the final denture, if done within one (1) year.

Inlays, Onlays, Crowns, Veneers: Expenses for inlays, onlays, crowns, veneers when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where significant areas of previous fillings and decay prevent the use of traditional filling materials to adequately restore the tooth.

Denture Adjustments: Expenses for denture adjustments once per *insured person* per *policy year.*

Initial Bridge Pontics and Fixed Bridge Retainers: Expenses for the initial bridge pontics and fixed bridge retainers on teeth extracted while the *insured person* is covered under this *policy*; if there were three or more teeth missing prior to the being eligible for coverage; GMS will pay for a partial denture only.

Replacement Bridge Pontics and Fixed Bridge Retainers: Expenses for the replacement bridge pontics and fixed bridge retainers must be separated by at least five (5) years.

Dental Conditions and Exclusions

The following conditions and exclusions apply to the Dental Benefits:

Dental benefits are available within Canada.

Services totalling $500 or more must have prior approval from *GMS* before the services re begun. If a dental pre-authorization is not submitted prior to commencement of services, benefits otherwise payable, may be limited to $500 for the services performed.

GMS will pay for services and procedures only to the maximum amounts as provided for in the *dental fee guide*. Any charges over and above the *dental fee guide* will be the *insured person*'s responsibility.

If the *insured person* and the *dentist* decide on a personalized restoration in the construction of a denture, or specialized techniques are employed as opposed to standard procedures, *GMS* will provide benefits at the appropriate amount for a standard denture and standard techniques. The provision of prosthetic devices including shall not be covered under this *policy* if the device was ordered or the service for the device was started before the effective date of coverage by this *policy*.

Multiple restorations submitted on the same tooth within twelve (12) months will be limited according *to reasonable and customary* charges as indicated in the *dental fee guide*. Replacement of identical restorations will only be covered once every twelve (12) months.

The following services or supplies are excluded from coverage:

a. expenses compensable under Worker's Compensation Laws or any Government Agency;
b. expenses for cosmetic purposes;
c. expenses associated with congenital defects, developmental malformations or temporomandibular joint disorders;
d. expenses for implants or crowns involved in an implant procedure and surgical insertion;
e. replacement of lost or stolen dentures or replacement/repair of orthodontic braces;
f. expenses for tissue grafts.

Definitions

Accidental/Accident: a happening to external, sudden, fortuitous causes beyond the *insured person*'s 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 the *insured person*'s *departure 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 the *insured person* is taking Coumadin/Warfarin for anticoagulation therapy and are required to have their blood levels tested on a regular basis International Normalized Ratio (INR) and their *medical condition* remains unchanged, yet the *insured person is* adjusting the dosage of *their* anticoagulation medication to ensure their INR is maintained within therapeutic range as directed by *the insured person*'s *physician(s)*; or
d. if the *insured person* is taking insulin or oral anti-diabetic medication for diabetes and are required to have *their* blood levels tested on a regular basis and their *medical condition* remains unchanged, yet the *insured person* is adjusting the dosage of *their* medication to ensure their blood glucose level is maintained within therapeutic range as directed by the *insured person*'s *physician(s)*.

Anniversary Date: the annual recurrence of the original date of issue of this *policy.*

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

Child: the *insured person*'s or *insured person*'s *spouse'*s son or daughter, including step-child, adopted child, or a child for whom custody has been granted pursuant to an Order of Court.

Couple: the *participant* and one (1) eligible *dependant*.

Dental Fee Guide: the current Dental Association Fee Guide of the province in which the *insured person* resides, including amounts listed for licensed specialist services. If the *insured person*'s *province of residence* does not have a fee guide, the dental fee guide adopted by *GMS* shall apply.

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

Departure Date: the day the *insured person* leaves their *province of residence***.**

Departure Point: the province, territory or country the *insured person* departs from on the first day of their intended travel period.

Dependant:

a. the *participant*'s *spouse* as defined below in *spouse*; and/or
b. any unmarried *child* of the *participant* or *participant*'s *spouse* as defined in *child* above, who is:
    i. under twenty-one (21) years of age and not working more than thirty (30) hours per week unless a full-time student;
    ii. under twenty-five (25) years of age if the *child* is participating in-full-time educational training in Canada and is chiefly dependent upon the *participant* or *spouse* for support and maintenance;

    or

iii. a developmentally or physically disabled *child*, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the *child* attaining the ages indicated above to ensure continuing eligibility. 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 supporting himself/herself financially due to a medically diagnosed physical or psychiatric condition.

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

Member: a person who is eligible for, and maintains active membership with Retire Alberta. The surviving *spouse* of a *member*, who meets eligibility requirements of this policy, shall be deemed to be a *member*, provided active membership in Retire Alberta is continued.

Members age sixty-four (64) or less as of the effective month of the coverage, are eligible for coverage under Class A. *Members* age sixty-five (65) or older as of the effective month of coverage are eligible for coverage under Class B.

Member Contribution: the amount, if any, which the *policyholder* requires a *member* to pay toward the premium for his/her benefit(s) under this *policy*.

Family: the *participant* and two (2) or more eligible *dependant*s. When the *policy* does not include *couple* premiums, family is the *participant* and one (1) or more eligible *dependant*s.

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

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

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

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

Heart Disease: any disease of the heart including but not limited to angina, irregular heartbeat, heart attack, congestive heart failure, ischemic heart disease, valvular heart disease and myocardiopathy.

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 *physician* always on duty and an operating room where surgical operations are performed by legally licensed medical *physician*s. In no event shall the term “hospital” or “general active *treatment* hospital” mean any hospital or institution or part of such hospital or institution licensed or used principally as a clinic, continued care or extended care facility, convalescent *home*, rehabilitation centre, rest *home*, personal care *home*, nursing *home*, health spa or *treatment* centre for drug addiction or alcoholism.

DEFINITIONS

Immediately Related: legal or common-law *spouse*, parent, sister, brother, legal guardian, step-parent, step*child*, step-sister, step-brother, grandparent, grand*child*, in-law, or natural or adopted *child*.

Insured Person: any *participant* or *dependant* as defined in this *policy* that is covered by this *policy.*

Medical Condition(s): are any irregularities in the *insured person*'s health:

a. for which the *insured person* received *medical treatment* or *medical consultation*;
b. related to undiagnosed symptoms for which the *insured person* 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 and/or symptoms in an effort to diagnose a *medical condition*, illness or injury; or for the purpose of evaluating the *insured person*'s progress and/or *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 the *insured person*'s trip, a medical emergency no longer exists when the medical evidence indicates that no further *medical treatment* is required at the *insured person*'s destination, or indicates that the *insured person* is able to return to their *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 medication*; investigative testing; in-*hospital* care; surgery; or other prescribed or recommended action directly referable to the applicable condition, symptom or problem.

Non-Adherence: the failure or refusal of the *insured person* to cooperate by carrying out that portion of the medical care plan under his or her control.

Ophthalmologist: a *physician* who specializes in the *treatment* of disorders of the eye.

Participant: the person(s) insured by this *policy* through a relationship with the *policyholder*.

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, but does not include a naturopath, herbalist or homeopath.

Policy: the contract between the *policyholder* and *GMS* including collectively, these terms and conditions, the declarations page, 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: the party referred to on the Declarations Page of the *policy*

Prescription Medication: 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.

DEFINITIONS

Province of Residence: the province or territory of Canada that the *insured person* has declared as his/her permanent residence and resides in for the required number of days outlined by their provincial or territorial health care legislation and/or *government health plan* in order to maintain their provincial or territorial 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 the *insured person* is contracted to return to their *province of residence*.

Spouse: a legal spouse by virtue of religious or civil marriage, or a person who has been residing with the *participant* continuously for a least one (1) year and who has been maintained and publicly represented by the *participant* as the *participant*'s spouse. A *participant* may only have one spouse at any given time.

Single: one (1) *participant*.

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

a. has not received new *medical treatment*;
b. has not been prescribed a new *prescription medication*;
c. has not had a change in *medical treatment*;
d. has not had an *alteration* in a prescribed medication;
e. has not experienced a deterioration in their condition;
f. has not experienced new, more frequent or more severe symptoms;
g. has not had or required *medical consultation* to investigate symptoms that remain undiagnosed;
h. has 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 their *province of residence*.

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

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 *the participant*'s application or a person with whom *the participant* have pre-paid accommodations or *transportation* for the same trip and who will accompany *the participant* throughout the trip, to a maximum of four (4) persons including the *participant*.

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

Unit: time measured in fifteen minute increments applicable to dental procedures.

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

GENERAL INFORMATION

ELIGIBILITY

Who is eligible to enroll?

Members

To be eligible to participate in this plan you must be:

- retired employee from the Province of Alberta, or the Alberta public sector,
- maintain membership in good standing with Retire Alberta,
- resident of Canada, and
- insured under a provincial *government health plan*.

Eligibility is contingent upon full payment of all required premiums.

To be eligible, *members* must have a valid health services card from their *province of residence* and remain in their *province of residence* for the required number of days outlined by their provincial health care legislation and/or *government health plan* in order to maintain provincial coverage.

Dependant

A *dependant* will be eligible for coverage on the latest of the following dates:

a. the date that the *member* becomes eligible for coverage under this plan; or

b. the date that the individual(s) becomes a *dependant* as defined in this booklet.

Your *spouse* and/or *dependant* children may also qualify for coverage based on the following:

- Your *spouse*, defined to be your legal spouse by virtue of a religious or civil marriage or a person who has been residing with you continuously for at least one (1) year and who has been maintained and publicly represented by you as your *spouse*;
- Benefits can be extended for a former *spouse* where you are required by court order to provide some or all of the benefits available under your plan.
- 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 *dependant* upon you or your *spouse* for support and maintenance:
    - under twenty-one (21) years of age and not working more than 30 hours per week, unless a full-time student;
    - under twenty-five (25) years of age if the *child* is undergoing full-time student educational training in Canada, who is chiefly dependent upon the *member* or *spouse* for support and maintenance; or

- a developmentally or physically disabled *child*, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the *child* reaching the ages indicated above (must be considered incapacitated due to a permanent mental or physical infirmity and incapable of supporting himself/herself financially due to a medically diagnosed physical or psychiatric condition).

If your *child* is suffering from a medically diagnosed permanent mental or physical infirmity, or is a student, for continued coverage beyond age 20 you must submit a written application within 31 days of your *child* reaching age 21 and supply proof of their infirmity, or status as a student.

A *child* for whom you or your *spouse* has been appointed guardian is not an eligible *dependant* unless Group Medical Services has received satisfactory proof of guardianship. If your insured *spouse* is the guardian, the insured *spouse* must be residing with you.

A *child* is not considered a full-time student if the *child* is being paid while attending a training or retraining program at an educational institution, excluding scholarships. If you have *dependant* children who are students over age 20, you must submit proof of student status each semester (by completing the student declaration form).

Notice of *dependant* eligibility must be provided in writing to Group Medical Services.

To be eligible, *dependants* must have a valid health services card from their *province of residence* and remain in their *province of residence* for the required number of days outlined by their provincial health care legislation and/or *government health plan* in order to maintain provincial coverage.

You can only insure one *spouse* at a time. You must insure the same person for all spousal benefits provided under this plan. You can change from one insured *spouse* to another by submitting an Enrolment/Change Form removing the current *spouse* and adding the new *spouse*.

A change from a common-law *spouse* to a legal *spouse* is only valid when the legal *spouse* is living with you. A change from a former *spouse* to a legal *spouse* is not allowed unless the court order under which the former *spouse* qualified for coverage has expired.

When does coverage begin?

Member's effective date

Your coverage becomes effective on the date you satisfy the *member* eligibility requirements.

Dependant's effective date

Your *dependant* coverage takes effect on the later of the following dates:

- the date your coverage begins
- the date the *dependant* becomes eligible for coverage

Extended health care coverage for a *dependant*, who is hospitalized on the date they become eligible for coverage, other than a newborn *child*, will be delayed until the first day immediately following his/her discharge from *hospital*.

When does coverage terminate?

Member's termination effective date

Your coverage under this plan terminates automatically on the earliest of the following dates:

a. the date of termination of the plan;
b. the end of the period for which premiums have been paid; or
c. the date on which you no longer meet the definition of a *member*, as provided by this plan.

A *member* may terminate coverage at any time by giving written notice to *GMS* at least sixty (60) days in advance. Termination shall take effect on the later of the date of termination stated in the written notice, or sixty (60) days after the written notice is received by *GMS*.

Changes to Coverage

In the event of a life change such as marriage, death, divorce, the addition or removal of a *dependant*, your family status can be downgraded or upgraded during the policy year. The change to your coverage and any required adjustment to premiums will be effective the first of the month following receipt of the request. The premiums for the change in coverage will remain in effect for the remainder of the entire policy year.

Dependant's termination effective date

The coverage of a *dependant* under this plan terminates automatically on the earliest of the following dates:

a. the date that the coverage is terminated for the *member*;
b. the date that the person no longer satisfies the definition of *dependant*, as provided by this plan;
c. the date on which the *dependants* age is cover the specified age in the Schedule of Benefits; or
d. the end of the period for which premiums have been paid.

Survivor Benefit

In the event of death of the *participant*, GMS will continue the Extended Health and Travel benefits and/or Dental benefits without payment of premium for the *dependant*(s) until the earliest of:

a. the date the *dependant* is no longer deemed a *dependant* as defined in this *policy*;
b. the date similar coverage is obtained elsewhere;
c. the date which is three (3) months after the death of the *participant*; or
d. the date the group policy terminates.

DUPLICATE COVERAGE WITH OTHER PLANS

What happens if I have coverage with another plan?

Group Medical Services will co-ordinate extended health care benefits payable under this plan with other plans which also cover you and your *dependant*s for similar benefits. After the benefits of the *government health plan*s have been determined, the excess benefits will be coordinated with those of other policies if the person is covered for similar benefits simultaneously under any other *policy*. Benefits payable from all plans will not exceed 100% of the actual allowable expenses.

For *member*s and their *spouse*s, the plan with no co-ordination of benefits (COB) provision in the *policy* or plan document determines benefits first (primary carrier). If the other plan(s) has a co-ordination of benefits provision, priority goes to the plan in the following order:

a. the plan where the person is covered as a *participant*;
b. if a person is a *participant* of two (2) plans, priority goes to:
    i. the plan where the person is an active full-time *employee*;
    ii. the plan where the person is an active part-time *employee*;
    iii. the plan where the person is a retiree; then
c. the plan where the person is covered as a *dependant spouse*; then
d. the private plan (Individual Health Plan) where the *insured person* is covered as a *participant*.

Example:

If your *spouse*'s plan covers 80% of an eligible serve, the remaining 20% can be submitted to Group Medical Services for reimbursement.

As a result, many people choose to retain both coverages indefinitely.

For children, plan priority is determined based on the following:

a. the plan of the parent with the earlier birth date (month/day) in the calendar year;
b. the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date;
c. in situations where parents are separated/divorced, then the following order applies;
    i. the plan of the parent with custody of the *child*;
    ii. the plan of the *spouse* of the parent with custody of the *child*;
    iii. the plan of the parent not having custody of the *child*; then
    iv. the plan of the *spouse* of the parent not having custody of the *child*.

How do I submit a claim for co-ordination of benefits?

To submit a claim when co-ordination of benefits applies, refer to the following guidelines:

Refer to the Duplicate Coverage with Other Plans section to determine which plan is the primary carrier and which is the secondary carrier. Your administrator can help you determine which plan you should claim from first.

Submit all necessary claim forms and original receipts to the primary carrier.

Keep a photocopy of each receipt. Once your claim has been settled by the primary carrier, you will receive an explanation outlining how your claim has been handled.

Submit this explanation along with all necessary claim forms and receipts to the secondary carrier for further consideration or payment, if applicable.

UPDATING RECORDS

To ensure that coverage is kept up to date for you and your *dependant*s, it is vital that you advise your *employer* or plan administrator of any changes. This includes a name change, change in marital status or *dependants*, change of beneficiary, or application for benefits previously waived.

How do I make sure I am still covered?

*Member*s leaving a *GMS* group are eligible for automatic acceptance into a Group Medical Services Individual Health plan within sixty (60) days of your group coverage ending. Visit www.gms.ca and go to the Individual Health Plans section, or call *GMS* Customer Care at 1.800.667.3699. All you need to do is fill out an application, with no medical questions and automatic acceptance. You choose the health plan and options that meet your needs.

Also Available from Group Medical Services

Individual Health – Supplemental health insurance coverage for everyday health needs unexpected medical emergencies and protection from rising health care costs. Add Dental Care, Prescription Drug, Travel and Hospital Cash Options.

Travel Insurance – Carefree travel with daily or out-of-country emergency medical coverage, trip cancellation/ interruption and add-on baggage insurance.

Immigrants and Visitors to Canada – Emergency health plan benefits for those newly arrived in or visiting Canada, including helpful assistance to coordinate treatment and care.

Student Plan – Health and travel coverage is perfect for post-secondary students studying away from *home*, in Canada or abroad.

PRIVACY STATEMENT

For over sixty years Group Medical Services has been safeguarding personal information about our valued members and their *dependants.* We want you to know that protecting your privacy is important to us.

Why do we collect your information?

When you first join Group Medical Services as a member or *dependant* under a group or individual plan we ask for some information about you. We use this information to:

- establish your identification,
- verify your eligibility for benefits and services,
- help us to process and pay claims submitted by you, and
- understand your needs and preferences.

We do not collect any of the above information that is not provided to us voluntarily and knowingly by you (or, in the case of a *dependant* under a group plan or individual plan, by your representative).

It is important to note that during the application process for one or more of our products or services, you (or, in the case of a *dependant* under a group or individual plan, your representative) may have provided us with written consent respecting the collection, use or disclosure of your information. This privacy statement is intended to supplement, and does not replace or modify, any such written consent.

As part of our ongoing relationship with you, we collect, keep and use additional information about you that is needed to provide the products and services you request, which includes using it to evaluate risk and manage claims. We collect information from you (or, in the case of a *dependant* under a group or individual plan, from your representative), either directly or through our representatives and agents. We may also collect information about you from sources such as *hospital*s, doctors and other health care providers, the government (including your provincial health plan) and other governmental agencies, other insurance companies, benefit carriers or other organizations under which you are covered, and your current or former *employer*(s).

As well, we use your information to communicate with you, to help us understand and appropriately respond to your current and future needs. We may use the information internally to compile statistics about our plans, which helps us understand the needs of our customers and our business.

When do we disclose information?

In the event one of our members, or their *dependant*s, is covered by a benefit plan with another benefit carrier, we may disclose his/her relevant information to the benefit carrier when we are coordinating benefit payments between our organizations. This is in accordance with our contractual obligation.

We may disclose a member or *dependant's* information to a person who seeks the information as an authorized representative of the member or *dependant* (e.g., lawyer, power of attorney, etc.). We may disclose a member or *dependant*'s information when required or permitted by law. When required by law to disclose information, we limit the information that we release to only what is required by the relevant law.

PRIVACY STATEMENT

How do we protect your information?

Unless we otherwise have your consent, we will not collect, use or disclose your information for any purposes other than what we've listed here.

We limit access to your information to only *employee*s in our organization, subcontracted *employee*s or our travel assistance firm who require access to the information in the performance of their job duties. We will take all reasonable steps to ensure that your information is accurate and current. It is important that you, or your benefit administrator, contact us with any changes to your information.

The choice is yours

We will continue to collect, use and disclose information for the purposes described in this document. However, subject to legal or contractual restrictions, you may (upon reasonable notice to us), 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 our ability to serve you at our best capability. Further, if you withdraw your consent, we may not be able to offer you our products and services and you may limit our ability to pay your claims.

Privacy related inquiries

We will respect your request for access to the information about you that we hold. If we have information that is not correct, you can correct your information so that it is complete and accurate. To correct or update your personal information, please contact one of our Customer Service Representatives at 306.352.7638, or toll-free at 1.800.667.3699, and they would be pleased to assist you.

If you have a specific request or question about our privacy practice, please send this to us in writing. In your correspondence please describe your questions in as much detail as possible. We will respond to your concern as promptly and accurately as possible.

Write to the attention of the Privacy Officer:

Group Medical Services
2055 Albert Street PO Box 1949
Regina, SK S4P 0E3

Group Medical Services
2055 Albert Street PO Box 1949 Regina, SK S4P 0E3
1.800.667.3699 www.gms.ca

Printed: Nov-23