Employee Benefit Booklet

«COMPANY_NAME»

«HEALTH_COVERAGE»
«DENTAL_COVERAGE»

Policy Number: <<GMS_#>>
Effective Date: <<APP_DATE>>
Revised day: <<RENEWAL_DATE>>

Underwritten By Group Medical Services

gms

Contents

Welcome

We're GMS. We're happy to provide you health benefits through your employer. The Schedule of Benefits in this booklet gives an overview of what's included in your plan and how to use it. Take a read through so you know what you're covered for. Your certificate of insurance is your personal summary of who's included under your plan and how much coverage you have.

If you have any questions, your plan administrator should be able to help. They're responsible for adding you to the plan if you're eligible. And it's up to you to give them the information they need to do so and update your information if anything changes.

How to use your benefits

First things first. Once you receive your GMS ID cards from your plan administrator, head to www.gms.ca to sign up for your My GMS account. Your account will let you submit claims online, sign up to have your claim payments deposited directly into your bank account, view your claims history and more.

Better yet, you can avoid paying out of pocket by using your GMS ID card for direct-pay. If your plan includes coverage for prescription drugs, dental services, or health and vision practitioners, you can present your ID card at participating providers. They'll bill us directly.

Online is best when it comes to submitting claims. But we'll accept them in the mail too. Print off a claim form from www.gms.ca, fill it out, attach original receipts and send it our way:

GMS

Attn: Claims Dept.,

2055 Albert Street PO Box 1949,

Regina, SK, S4P 0E3

Submitting a claim for coordination of benefits?

If you're covered under two plans, you'll have to determine which plan is the primary carrier and which is the secondary carrier. Check in the Coordination of Benefits section of this booklet or ask your plan administrator to help you determine which plan you should claim from first.

Submit all necessary claim forms and original receipts to the primary carrier and keep a photocopy of each receipt. Once your claim's been settled by the primary carrier, you'll receive an explanation of benefits outlining how your claim's been handled.

If the primary carrier doesn't cover the entire expense, submit a claim to the secondary carrier and include the explanation of benefits.

Be sure to submit your claims within 12 months of purchase and hang on to copies of your original receipts.

Schedule of Benefits

Waiting Period is «Waiting Period» months of continuous employment for all benefits.
Hours per week (minimum): 20 hours.

Health Benefits – Platinum 3	Percent Eligible	Per Insured Person, per Policy Year *(unless stated otherwise)*
Deductible **Termination Age**		**Nil** **Retirement; Travel ends at age 80**
Prescription Drugs	100%	$20,000 Lowest cost alternative Formulary & Non-Formulary
Vision *Eye Exams* *Prescription Eyewear [glasses, sunglasses, contact lenses, refractive laser eye surgery)*	100%	$300 per Insured Person, per 2 Policy Years, including the current Policy Year
Health Practitioners (acupuncture, massage therapy, dietician, chiropractic, physiotherapy/ athletic therapy, naturopath, osteopathy, speech therapist, chiropody/podiatry)	80%	$500 per specialty
Mental Health Practitioners (Psychologist, social worker, psychotherapist, clinical counsellor)	100%	$500
Diabetic Supplies & Equipment	100%	$500
Custom Made Foot Orthotics	100%	1 pair per 5 years (adult) / 1 pair per Policy Year (Dependents 16 yrs and under), including the current Policy Year
Orthopedic Shoes	100%	$250
Semi-Private Hospital Rooms	100%	Unlimited
Private Duty Nursing	100%	$5,000
Hearing Aids	100%	$500 per Insured Person, per 3 Policy Years, including the current Policy Year
Accidental Injury to Natural Teeth	100%	$2,000 per injury
Ambulance Road Air Return	 100% 100% 50%	Unlimited
GMS Care Network	100%	Unlimited short-term counselling services, telemedicine, iCBT
OOC Travel Benefit	100%	90 days per trip; $5,000,000 Lifetime Maximum
Out-of-Province Referral (within Canada)	100%	$50,000 lifetime maximum, per Insured Person
Blood Pressure Monitors	100%	1 per family, per 5 policy years, including the current policy year
Ostomy Supplies	100%	$300
Oxygen Equipment	100%	$500
Breast Prosthesis	100%	1 if lateral / 2 if bilateral, per 2 Policy Years, including the current Policy Year
Surgical Bras	100%	2 surgical bras per 2 policy years
Wheelchairs, Motorized Scooters & Hospital Beds	100%	$500 per 5 Policy Years, including the current Policy Year
Patient Walkers	100%	$200 per 3 Policy Years, including the current Policy Year

Casts and Crutches	100%	Unlimited
Prosthetic Appliances	100%	$10,000 lifetime maximum, per Insured Person
Health Supplies & Equipment	100%	$500 Combined for health supplies & equipment and mobility aids
Compression Stockings	100%	4 pairs per policy year

Dental Benefits - Gold	Percent Eligible	Per Insured Person, per Policy Year *(unless stated otherwise)*
Deductible **Termination Age**		**Nil** **Retirement**
Basic Restorative Services (includes Endodontic & Periodontic services)	100%	$500, $1000, $1500 or $2000 Combined annual maximum
Major Restorative Services	50%	

General information

Eligibility & Commencement of Coverage

Employee

*You'*re eligible to be covered under this plan on the date *your* employment begins or after completing the waiting period determined by *your* employer.

If *you* don't apply for coverage within thirty-one days of becoming eligible, *your* coverage will begin on the date we accept *your* completed medical questionnaire. Please see the Late Applicant section of this policy for more details.

To be eligible for coverage under this plan, *you* must be working a minimum of 20 hours each week on a full-time, permanent basis, part-time basis, or as a term employee. Temporary and seasonal employees may not join the plan.

You must be actively at work when coverage takes effect. Otherwise, *your* coverage will begin on the date *you* return to work.

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

You may waive health and/or dental coverage if *you*'re covered for those benefits under another plan. If *you* lose coverage under the other plan, *you* must apply for coverage under this plan within 31 days of loss of coverage.

Dependent

Your dependents are eligible for coverage on the same date *your* coverage begins or the date they become a *dependent* as defined in this booklet, whichever date is later.

You must notify us in writing within 30 days of the *dependent* becoming eligible under this plan. If *you* request coverage for a *dependent* more than 30 days after they become eligible, they'll be covered only if and when we provide written approval of the request.

Changes affecting your coverage

We know life changes for a variety of reasons. Whether it's adding or removing a family member, leaving your position for a different job, or having *your* employer switch benefits providers, it's important to note the following:

Updating & Accessing Records

It's important to notify *your* employer or plan administrator of any changes to *your* personal information to make sure coverage is kept up-to-date. This includes a name change, change in marital status or *dependent*(s), change of beneficiary (if applicable), or application for benefits previously waived.

For insured benefits, *you* can request copies of documents *you* provided when enrolling in this plan. And with reasonable notice, *you* may also request a copy of the contract.

Termination

Employee

Your coverage ends at the earliest of the following dates:

1) the date *your* employment ends;

2) the date this benefits plan ends;

3) the end of the period for which premiums have been paid for *you*;

4) the date *you'*re no longer eligible for coverage. If *you*'re away from work due to injury or sickness, maternity or parental leave, leave of absence or temporary lay-off, and the payment of premiums continues, *you*'ll be covered until the earliest of the following dates:

   a. twelve months after *you* no longer meet the definition of "employee", except if *you*'re off on maternity or parental leave;

   b. the date *you* begin working for another employer for more than 20 hours each week; or

   c. the date determined by the employer to prevent individual selection.

Dependents

Coverage of *your dependen*t(s) under this plan ends automatically on the earliest of the following dates:

1) the date this benefits plan ends;

2) the end of the period for which premiums for *dependent* coverage have been paid for *you*;

3) the date the person no longer meets the definition of a "*dependent*" or otherwise meets the eligibility requirements set out in this booklet; or

4) the date *your* coverage under this plan ends.

Survivor Benefits

In the event of *your* death while covered under this plan, we'll continue extended health, travel, and dental benefits, as applicable, for your *dependen*t(s) without payment until the earliest of:

1) the date the *dependent* no longer meets the definition of "*dependent"* as defined in this booklet;

2) the date similar coverage is obtained elsewhere;

3) twelve months after *your* death; or

4) the date this benefits plan ends.

Replacement Coverage

If *your* company switched from another benefits provider to GMS, this group contract will be interpreted and administered according to the guidelines of the Canadian Life and Health Insurance Association or any applicable legislation concerning the continuation of insurance following contract termination and the replacement of that contract of group insurance.

GMS will not be responsible for paying benefits if an insured under a previous group contract is responsible for paying similar benefits.

Legal Actions

Every action or proceeding against GMS for the recovery of insurance money payable under the policy is barred unless commenced within the time set out in the relevant legislation in the jurisdiction where the action is commenced.

Recovering Overpayments

GMS has the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

Coordination of Benefits

What happens if I have coverage with another plan?

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

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.

If an *insured person* is entitled to benefits for the same expenses under another plan, contract, or policy, benefits will be coordinated so that the total benefits from all plans will not exceed expenses and in accordance with the Canadian Life & Health Insurance Association guidelines.

If the other responding contract or plan does not contain a co-ordination of benefits of provision, the co-ordination of benefits provision in this policy will take precedent and determine the co-ordination of benefits between the two plans. If the other plan contains a co-ordination of benefits provision, priority goes to the plan in the following order:

1) The plan where the *insured person* is covered as a member;

2) If the *insured person* is a member of two plans, priority goes:

3) The plan where the *insured person* is actively at work on a full-time basis;

4) The plan where the *insured person* is actively at work on a part-time basis;

5) The plan where the *insured person* is a retiree;

6) The plan where the *insured person* is covered as a spouse;

7) The private plan or individual health plan where the *insured person* is covered as a member.

Example:

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

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

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

1) the plan of the parent with the earlier birth date (month/day) in the calendar year;

2) the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date;

3) in situations where parents are separated/divorced, then the following order applies;

a. the plan of the parent with custody of the Child;

b. the plan of the Spouse of the parent with custody of the Child;

c. the plan of the parent not having custody of the Child; then

d. the plan of the Spouse of the parent not having custody of the Child.

Definitions

Here are the definitions of some of the important terms that appear within this booklet.

Accident: A happening due to external, sudden, fortuitous causes beyond the *insured person*'s control

Dependent:

1) Employee's spouse;

2) any unmarried child of the employee or employee's spouse, who is:

   a. under twenty-one (21) years of age and not working more than thirty (30) hours per week unless a full-time student;

   b. under twenty-five (25) years of age if the child a full-time student in Canada, who is chiefly *dependent* upon the employee or spouse for support and maintenance; or

   c. a developmentally or physically disabled child, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the child attaining the ages indicated above to ensure continuing eligibility. 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.

Emergency: a sudden and unforeseen medical condition that requires immediate *treatment*. In the case of an *emergency* incurred during the *insured person*'s trip, a medical *emergency* no longer exists when the evidence reviewed by GMS indicates that no further medical *treatment* is required at destination, or the *insured person* is able to return to his/her province of residence for further medical *treatment*.

Employee: a person having a continuing employment relationship with his/her employer on an active, full-time permanent basis, part-time basis or as a term *employee* working a minimum of twenty (20) hours per week. This definition excludes, without limitation, the following:

1) any person operating as independent contractor where federal tax, CPP and EI are not remitted by the employer

2) any person employed on a temporary (less than 12 months) or seasonal basis;

3) any person receiving a pension arranged by the employer because of previous employment of the person by the Employer; and

4) any person on strike or locked-out under applicable labour relations legislation.

Insured Person: any *employee* or *dependent* that is covered by through the employer's policy.

Medically Necessary: a *treatment*, service or supply which is generally accepted by the medical profession as essential, effective, and appropriate in the care and *treatment* of a medical condition, sickness or injury.

Reasonable and Customary: charges incurred for goods and services that are comparable to what other providers charge for similar goods and services in the geographical area where the goods and services were purchased or received.

Stable: any *medical condition* or related *medical condition*, related directly or indirectly to the *insured person's* original condition, for which in the one hundred and eighty (180) days prior to departure:

1) there have been no new symptoms, more frequent or more severe symptoms;

2) there has been no change in *treatment* or change in medication (any newly prescribed medication, change in medication type, increase/decrease in dosage or discontinuation of a medication constitutes a change. A change from a brand name medication to a generic brand medication of the same dosage does not constitute a change in medication);

3) there has been no deterioration of the *insured person's medical condition*;

4) there has been no hospitalization or referrals to a specialist including initial follow-up visits, tests or investigations booked in conjunction with a *medical condition* or symptom of a *medical condition*;

    a) there is no further testing, *treatment* or investigation booked or results pending;

    b) The *insured person* has not experienced a symptom that remains undiagnosed; and

    c) no further medical *treatment* after departure from the i*nsured person's province of residence* is anticipated.

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.

You/your: an *employee* covered for benefits through their employer

Extended Health Care Benefits

Extended Health Care benefits help *you* and *your dependent*(s) (*insured persons*) pay for the cost of eligible expenses that are *medically necessary* and *reasonable and customary* as a part of *treatment*. *Your* Schedule of Benefits at the front of this booklet outlines the deductibles, co-insurances and benefit maximums that apply to *your* plan.

When *you* make a claim, *reasonable and customary* amounts and frequency limitations will be applied as necessary. A list of *reasonable and customary* charges can be found in *your* My GMS portal.

To be eligible for this benefit *you* and *your dependent*s must have government health insurance in Canada. Extended Health Care benefits are only available within Canada unless otherwise noted.

Any expense that's payable under this plan will be reduced by the amount the *insured person* received or is eligible to receive through:

- any government health insurance plan
- worker's compensation legislation or similar statute

All eligible expenses will be applied within the benefit year the claim was incurred whether or not the claim was submitted within the benefit year

If *you* expect an expense to be more than $500, we recommend submitting a detailed *treatment* plan to us before starting *treatment*. This process will identify the cost *you*'ll be responsible for and will give you an opportunity to discuss alternative *treatment* options with *your* health care provider, if necessary. For benefits to be paid, *you* must be eligible for coverage on the date the expense is incurred.

Health Benefit Details

Health Practitioners / Mental 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.

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 the hospital

Wheelchair, 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. 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. An estimation must be submitted for review before purchase.

Hearing Aids

Payment for repair of, or purchase of a new hearing aid when prescribed by and/or and fitted by an audiologist or as legislated in the *insured persons* province of residence

Oxygen

Provides payment for the rental or purchase of oxygen equipment when prescribed by a physician for personal use in the home

Provides payment for the purchase of CPAP supplies when prescribed by a physician for personal use in the home.

Custom Orthotics

Provides payment for custom made foot orthotics. To be eligible for coverage a written prescription, including a medical condition, is required from an orthopedic surgeon, an attending physician, pedorthist, chiropodist/podiatrist or certified or orthotist

Orthopedic Shoes

Provides payment for the purchase of the cost of one pair of custom shoes or to modify one pair of off-the-shelf orthopedic shoes. To be eligible for coverage a written prescription, including a medical condition, is required from an orthopedic surgeon, an attending physician, Pedorthist, chiropodist/podiatrist or certified orthotist.

Ostomy Supplies

Provides payment for ostomy supplies when required for personal use in the home

Preferred Hospital Rooms

Reimbursement of semi-private hospital room costs

Diabetic Supplies

Payment for the purchase of diabetic supplies and equipment, including insulin pumps and testing devices, when ordered in writing by a physician for use in the home. This benefit excludes insulin and other prescription medications

Private Duty Nursing

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

Accidental Injury to Natural Teeth

Payment for the services of a dentist necessitated by accidental injury to natural or permanently attached artificial teeth, such as a direct blow to the mouth, but not by an object placed in the mouth.

The injury must be reported within six months so the *accident* occurring and coverage must be in place and continuous from the date of injury to the date that dental services are provided in order for this benefit to be payable. Payment for any claim is based on the date services are rendered and not on the date of injury. All services must be completed within twelve months of the date of injury.

Casts and Crutches

Payment for the costs of 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

Prosthetic Appliances

Payment of the purchase of artificial eyes, limbs and Larynx

Ostomy Supplies

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

Breast Prothesis and Surgical Bras

Payment for the purchase of an artificial breast prosthesis

Blood Pressure Monitors

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

Health Supplies and Equipment

Payment for the purchase or rental of splints, braces that contain metal or hard plastic components

Payment for the purchase of wigs, trusses, rib belts, air casts, clavicle straps, cervical collars, shoulder immobilizers, sacroiliac corsets and aero chambers. Payment for the purchase of canes, reaching aids, raised toilet seats, grab bars, bathtub/toilet safety rails, transfer benches.

The above items require a prescription from a *physician.*

Compression Stockings

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

Out of Province Referral

Payment for physician, anesthetic, radiology, laboratory, hospital and ambulance services outside of the *insured persons* province of residence, for *treatment* which is not available within the *insured persons* province of residence, when recommended in writing by a physician. The claim must have prior approval from GMS. We will not approve payment for *treatment* where there are government funded *treatment* options available within the *insured persons* province of residence. Payment will not be made for *treatment* related to any condition, disease or illness that existed in the twelve months prior to the effective date of the policy

Prescription Drugs

The Prescription Drugs benefit covers formulary and non-formulary drugs with a Drug Identification Number (DIN) as issued by Health Canada when ordered in writing by a physician.

If *you* take brand name prescription drugs, payment will be made up to the cost of the generic substitution. And in some cases, we'll pay for the brand name drug if the lowest cost alternative is not available when *you* fill *your* prescription. See *your* Schedule of Benefits for details.

Your pharmacist can help *you* determine if *your* prescription is covered under this plan and whether prior authorization is required.

Prescription Drugs Limitations

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

GMS reserves the right to determine which drugs, either new to the marketplace or existing, will be eligible for reimbursement under Health Benefits.

GMS does not cover drug or drug supplies that appear on the exclusion list maintained by GMS. GMS may exclude coverage for all expenses for a drug or drug supply, or only those expenses that relate to the *treatment* of specific diseases or injuries or the stages or progressions of specific diseases or injuries. GMS may add or remove drug or drug supply from an exclusion list at any time.

GMS does not cover:

1) First aid supplies, diagnostic supplies or testing equipment;

2) Oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas, or injectable total parenteral nutrition solutions;

3) Smoking cessation products;

4) Fertility drugs;

5) Obesity drugs;

6) Any drug that does not have a drug identification number as defined by the *Food and Drugs Act*, Canada;

7) Drugs administered during *treatment* in an *emergency* room of a hospital or as an in-patient in a hospital;

8) Drugs that do not require a prescription by law;

9) Drugs that are considered cosmetic, including but not limited to minoxidil, sunscreens, whether or not prescribed for a medical condition or reason;

10) Preventative immunization vaccines or toxoids;

11) Drugs to treat erectile dysfunction;

Vision Care

Eye exam: Provides payment for an eye exam by a qualified physician, optometrist or ophthalmologist, to measure the visual acuity of the patient.

Lenses, frames, contacts: Provides payment for prescription lenses, frames, contact lenses, and/or refractive laser eye surgery.

Health Conditions Limitations

The following conditions and exclusions apply to the Health Benefits:

- Health benefits are available within Canada.
- Services totaling $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.
- 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.
- The following services or supplies are excluded from coverage:
- expenses compensable under Worker's Compensation Laws or any Government Agency;
- expenses for cosmetic purposes;
- Expenses for diagnostic or investigative testing;
- Expenses from services provided by family members;

- Expenses for Positive Airway Pressure (PAP) Machines;
- Expenses for examinations related to surgical procedures;
- Expenses for post-surgical lenses;
- Expenses relating to non-prescription eyeglasses or non-prescription sunglasses;
- Expenses when no transport occurs or for transportation to or from physicians' offices, laboratories, and medical clinics.

Travel Benefits

The details of *your* travel benefits are listed in *your* Schedule of Benefits at the beginning of this booklet. Benefits are only payable if the event is an unexpected medical *emergency* that occurs outside of Canada. If *you* have travel coverage through another health plan, we'll subtract the amounts covered by those plans from *your* reimbursement.

Hospitalization

Payment for semi-private hospital rooms and hospital services and supplies necessary for the *emergency* care during hospitalization. One follow-up visit (excluding on-going treatment) is covered in situations where the medical process in dealing with the *emergency* required such a follow-up visit. The follow-up visit must take place within fourteen days of the initial *emergency*

Medical Services

Treatment by a physician or surgeon

Diagnostic Services

Payment of x-rays and other diagnostic tests. Magnetic Resonance Imaging, Computerized Axial Tomography scans, sonograms, ultrasounds, and biopsies are excluded unless pre-authorized by GMS

Out-Patient Treatment

Outpatient *emergency* room expenses

Prescription Drugs

Payment of drugs and medication obtained on the prescription of the attending physician or surgeon and supplied by a licensed pharmacist, to a maximum of thirty-day prescription. Drugs or medications that are lost, stolen or damaged during a trip during *your* coverage period are covered up to a maximum of $50 per person. Any associated physicians' expenses related to lost, stolen or damaged drugs or medications are excluded from coverage

Private Duty Nursing

Payment for the professional services of a registered nurse for private duty nursing while hospitalized during an acute *emergency* illness or injury to a maximum of $5,000 per *insured person* per incident to the overall travel maximum

Rental of Essential Medical Appliances

Payment for the rental of essential medical appliances (wheelchair, crutches, canes, etc.) when needed due to a medical *emergency* that occurred on the *insured persons* trip. The rental expense must not exceed the cost of purchasing the appliances. Pre-approval of GMS is required

Emergency Dental Services

Payment for the services of a dentist necessitated by accidental injury to natural or permanently attached artificial teeth, such as a direct blow to the mouth, but not by an object placed in the mouth to a maximum of $2,000 per person per incident to the overall travel maximum

Expense for the treatment or the relief of dental pain for any dental *emergency* other than that caused by an accidental blow to the mouth to a maximum of $250 per person per incident to the overall travel maximum

Health Practitioners

Payments for the services of an osteopath, physiotherapy, chiropractor, chiropodist or podiatrist to a maximum of $300 combined per person per incident to the overall travel maximum

Road Ambulance

Payments for the use of a licensed road ambulance in a medical *emergency* that required immediate transportation to the nearest hospital with adequate facilities

Air Ambulance

Payments for the use of an air ambulance in a medical *emergency* involving life threatening circumstances where *you* require immediate transport to the nearest hospital with adequate facilities to treat *your* medical *emergency* to a maximum of $20,000 per person per incident to the overall travel maximum.

Remote Evacuation

Payments 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

Expense 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

Special Attendant

Expense of the round-trip transportation for the transport of a medical attendant to accompany the *insured person* back to their province of residence when ordered by the attending physician. The attendant must not be a friend, family member, associate or travelling companion

Return of Family Member

Expense for one-way air transportation to return one accompanying family member insured as a *dependent* under the *insured person*'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 even to the *insured persons* death

The benefit is payable to the maximum of $1,000 per person per incidence to the overall travel maximum and requires pre-approval from GMS

Return & Escort of a Dependent Child

Expense for one-way transportation to return the *insured persons dependent* child or children travelling with them, who are under the age of eighteen to the *insured persons* 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 and required pre-approval from GMS

Family to Bedside

Payments for a round-trip, economy class airfare in the even the *insured person* becomes hospitalized for at least three consecutive nights as a result of a covered *emergency*, and the attending physician advises the necessary attendance of one family member or close friend to a maximum of $3,000 per incidence to the overall travel maximum

Expense reimbursement for *reasonable and customary* expenses incurred by the transported person once they arrive of $150 per day to a maximum of $750 to the overall travel maximum

Family Transportation

Payments for round-trip air transportation to provide for the return of a family member who is required to attend to identify the *insured persons* remains in the case of their death due to a medical *emergency* to a maximum of $2,000 per person per incidence to the overall travel maximum.

Payments for *reasonable and customary* expenses incurred by the transported person once they arrive $300 per person per incidence to the overall travel maximum

Return of Remains

Payments for the preparation and transport of the *insured persons* remains to their province of residence, or cremation or burial at the place of death, when the *insured persons* death was as a result of the medical *emergency* to a maximum of $3,000 per person for preparation and transportation and another $2,000 for cremation or burial to the overall travel maximum

Return of Vehicle

Payments to return the *insured persons* 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 companions are unable to do so because the *insured person* has been returned to their province of residence for further in-hospital medical treatment. *Reasonable and customary* expenses for this benefit include the vehicle being returned by a professional agency or the following incurred by an individual other than 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. The benefit maximum is $2000 per trip to the overall travel maximum and pre-approval by GMS is required

Return of Personal Pet

Payments 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 to a maximum of $300 per trip to the overall travel maximum.

Child Care

Payments for licensed care of *dependent* child or children who rely on the *insured person* for assistance, if they are traveling with the *insured person*, should the *insured person* require in-hospital care to a maximum of $500 per trip to the overall travel maximum. Pre-approval by GMS is required

Out of Pocket Expenses

Expenses incurred by a traveling companion covered as a *dependent* of the *insured person* in the event the *insured person* is in hospital receiving care on their return date up to $150 per day to a maximum of $1000 per person per incidence to the overall travel maximum. 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 *dependent(s)* travelling with the *insured person*, for up to seventy-two hours after the *insured person* is discharged from the hospital

Travel Limitations

In addition to the healthcare limitations the following limitations apply to travel outside Canada:

Coverage for any medical conditions and symptoms that existed prior to the departure date from the *insured person's* Province of Residence are subject to the following:

1) This Policy does not provide coverage for any expenses related directly or indirectly as a result of:

    a. The *insured person's* medical condition(s), a related condition(s), and symptom(s) (whether or not the diagnosis has been determined) if at any time in the one hundred and eighty (180) days preceding the *insured person's* departure date from their province of residence their medical condition(s), related condition(s), and symptom(s) have not been stable.

The *insured person* or someone on their behalf must contact GMS prior to treatment whenever possible. Failure to contact GMS within twenty-four (24) hours of receiving medical treatment or admission to hospital will limit benefits otherwise payable to 70% of eligible charges to an aggregate maximum of $50,000.

When taking multiple trips outside of Canada, all *insured person*'s must return to their province of residence prior to making a subsequent trip in order to be eligible for the maximum trip length of the policy. This condition does not apply in cases where trip duration is less than fourteen (14) days. However, all conditions and exclusions are applicable to each subsequent trip.

If the *insured person* incurs eligible travel expenses, they will also need to provide GMS the original copy of the itemized account of expenses, proof of departure date, the name of any other travel insurance provider, a copy of each policy, and particulars of all provincial health plan payments.

GMS, in consultation with the attending physician, reserves the right to transfer the *insured person* to another Hospital or medical facility capable of providing the necessary medical services, or to return the *insured person* to their province of residence. If the *insured person* refuses to do so, GMS will have no further liability under this policy.

If the *insured person*'s medical condition permits him or her to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

The *insured person* agrees that GMS is authorized to receive reports indicating diagnosis and services or treatment rendered or provided to the *insured person* from any physician, health care provider, other person, hospital or institution.

Maximums are payable per person per policy year, unless otherwise stated.

It is the responsibility of the *insured person* to provide proof that the dates of travel are consistent with the terms of this policy.

GMS Care Network

Provides You and Your Dependents with wellness services to help improve your mental, physical, financial and social wellbeing. You and Your Dependants have access to the following:

Assistance Program Accessible and personalized care across the health spectrum for 5 hours of counselling for You (and Your Dependents, if applicable) plus couples therapy (if applicable). Therapy sessions are booked online and delivered through a secure and encrypted platform by video or phone. The service is confidential, voluntary, and accessible at your convenience.

Telemedicine Access instant virtual telemedicine service with a network of Doctors. This benefit will allow You and Your Dependents to connect with general practitioners 24/7/365, communicate via text message, audio or video chat, manage and store your medical records, receive medical advice, prescriptions.

Internet-Based Cognitive Behavioral Therapy (iCBT) A digital program that uses Cognitive Behavioural Therapy (CBT) to help people with mild to moderate anxiety and depression achieve their wellness goals. Interactive learning modules, tools, and coaching to help develop positive coping strategies and reduce life-disrupting symptoms without waiting.

GMS Care Network can be accessed anytime by calling **1-866-798-6793**

Dental Care Benefits

Dental Care benefits help *you* and *your dependent*(s) (*insured persons*) pay for the cost of eligible expenses provided by a licensed dentist, denturist, dental hygienist, and anesthetist that are *reasonable and customary* as a part of treatment.

Reimbursement of the cost of dental expenses may be subject to deductibles, co-insurances and benefits maximums. See *your* Schedule of Benefits at the front of this booklet for details.

Regardless of where *you* receive treatment, the amount covered for dental treatments will be based on the current dental association fee guide in *your* province of residence. If a fee guide is not published for a given year, GMS has the right to create an adjusted fee guide.

Regardless of who *you* see for treatment, fees will be reimbursed based on the fee guide for general practitioners. And we will not pay more than the reasonable cost for the least expensive alternate procedure.

For implant-related crowns or prothesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or non-implant related prosthesis, respectively. We will factor in any limitations that would have been applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

Any expense that's payable under this plan will be reduced by the amount the *insured person* received or is eligible to receive through:

- any government health insurance plan
- worker's compensation legislation or similar statute

All eligible expenses will be applied within the benefit year the claim was incurred whether or not the claim was submitted within the benefit year

If *you* expect an expense to be more than $500, we recommend submitting a detailed treatment plan to us before starting treatment. This process will identify the cost *you*'ll be responsible for and will give *you* an opportunity to discuss alternative treatment options with *your* health care provider, if necessary. For benefits to be paid, *you* must be eligible for coverage on the date the expense is incurred.

If *you* or *your dependent*(s) (*insured persons*) apply for the coverage more than 31 days after becoming eligible for the plan, the dental benefits available for that year will be limited to a maximum of $250 per individual.

Basic Dental Services

Scaling and periodontal root planing

Included with ten units per person per policy year combined

Polishing

Includes two units per person per policy year

Application of topical fluoride

Treatment up to two units per person per policy year

Pit and fissure sealants

Covered one per tooth per lifetime for *dependent* under age eighteen

Space maintainers and maintenance

Included when a dentist has removed a primary tooth and an appliance is used to maintain space for a permanent tooth

Occlusal adjustment and equilibration

Included up to four units per person per policy year

Protective mouth guard appliances

One appliance allowable per policy year for *dependents* under sixteen and one per three policy years for *insured person* sixteen and over

Interproximal disking of teeth is included

Dental appliances

For the control of oral habits including bruxism appliances are included once per policy year for *dependents* under age sixteen and one per three policy years over age sixteen. Excluded from this benefit are expenses or appliances associated with obstructive sleep apnea, snoring or upper airway resistance syndrome (UARS)

Complete Dental Examination

This includes history, medical and dental; clinical examination and diagnosis once per *insured person* per three policy years

Limited Oral Examination

Payments for recall and specific examinations are covered twice per *insured person* per policy year subject to a combined maximum of two examinations per policy year

Payments for *emergency* examinations are included up to the overall dental maximum

Dental Radiographs

A complete (full mouth) or panoramic series once of either type per *insured person* per three policy years

Intra-oral and extra-oral bitewings are covered at ten films per person per two policy years

Treatment planning and consultation services

Included up to the overall dental maximum

Basic Oral Surgery

Payments for erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions and post-surgical care

Basic Restorations

Payments including caries, trauma, and pain control, amalgam restorations, prefabricated restorations and composite restorations

Endodontic treatment for permanent teeth

Payments for the treatment of the pulp chamber, root canal therapy, periodical services, miscellaneous surgical services (root amputation, hemisection, replantation, and perforations), and miscellaneous endodontic procedures including open and drain and non-vital bleaching. Root canal therapy is limited to one tooth per five policy years to the overall dental maximum

Endodontic Re-treatment

Payments for treatment of a previous root canal is covered for one tooth per five policy years to the overall dental maximum

Diagnostic Casts

Included once per person per three policy years

Anesthesia

Included and covered up to the overall dental maximum

Non-Surgical/Surgical periodontal services

Payments for the non-surgical services related to management of oral disease and desensitization is limited to one per site (sextant) per *insured person* per policy year

Payments for the surgical services related to gingival curettage, gingivoplasty, gingivectomy and flap approach is limited to one per site (sextant) per *insured person* per policy year

Relining and rebasing of dentures

Payments are covered up to the overall dental maximum once per person per three policy years

Removable Prosthodontic Services

Payments for denture repairs and additions, tissue conditioning for dentures and miscellaneous denture services (resilient liner and resetting of teeth) is available up to the overall dental maximum

Fixed Prosthodontics Repairs

Payments for replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, recementation, and fixed bridge/prosthesis repairs to the overall dental maximum

Major Dental Services

Inlays, onlays, crowns, veneers

Payments for when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where significant area so previous fillings and decay prevent the use of traditional filling materials to adequately restore the tooth up to the overall dental maximum. Replacements must be separated by at least five policy years

Complete and or partial dentures

Payments for initial, complete or partial dentures when at least one tooth being replaced was extracted while the *insured person* is covered under this policy, to the overall maximum for dental.

Replacement of Dentures

Payments for replacement of complete or partial dentures when at least one tooth being replaced was extracted while insured under this policy or provided the existing complete or partial denture is at least five years old. The cost of transitional dental work will be deducted from the final bridge or denture, if done within one year

Denture Adjustments

Payments are covered one per *insured person* per policy year up to the overall dental maximum

Initial bridge pontics and fixed bridge retainers

Payments for initial bridge pontics and fixed bridge retainers when at least one tooth being replaced was extracted while the *insured person* is covered under this policy; if there are three or more teeth missing in the arch, prior to the *insured person* being eligible for coverage; GMS will pay for a partial denture only up to the overall dental maximum

Replacement Bridges

Payments for replacement of bridge pontics and fixed bridge retainers when at least one tooth being replaced was extracted while insured under this policy, or provided the existing bridge is at least five years old.

Dental Limitations

Alternative Benefit Clause:

When two or more acceptable treatment options exist, payment by GMS will be limited to the most cost-effective treatment within acceptable dental standards. Should the *insured person* and his/her dentist choose a more expensive treatment, the *insured person* is responsible for any additional charges beyond the allowance for the alternative service. Where there is a dispute as to the most cost-effective treatment within dental standards, the determination of GMS shall be final.

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

GMS will only cover standard cast chrome with external clasp retainers or acrylic partial denture. When an alternate appliance is supplied, GMS will pay the standard rates.

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.

GMS will pay only for x-rays performed by a dentist.

The provision of prosthetic devices including complete dentures, partial dentures, fixed bridgework, and crowns that are part of the bridgework shall not be covered under this policy if the device was ordered or the service for the device was started before the 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 of the *insured person*'s province of residence. Replacement of identical restorations will only be covered once every twelve (12) months.

The following services or supplies are excluded from coverage:

1) Expenses compensable under Worker's Compensation laws or any government agency;

2) Expenses for cosmetic purposes;

3) Expenses associated with congenital defects, developmental malformations or temporomandibular joint disorders;

4) Expenses for implants or crowns involved in an implant procedure and surgical insertion;

5) Replacement of lost or stolen dentures;

6) Replacement and repair of orthodontic braces;

7) Expenses incurred to increase vertical dimension and repair or restore teeth damaged or worn due to attrition or vertical wear; and

8) Expenses for tissue grafts.

Privacy Statement/Respecting Your Privacy

Your privacy is important to us. We've been safeguarding our plan members' personal information for over 70 years,

Why do we collect your information?

When *you* first join GMS as a member or *dependent* 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*
- 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 *dependent* under a group plan or individual plan, by *your* representative).

It's important to note that during the application process for one or more of our products or services, *you* (or, in the case of a *dependent* 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 *dependent* 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 hospitals, doctors and other health care providers, the government (including *your* provincial/territorial health insurance 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?

If one of our members, or their *dependent,* 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 with an affiliate, reinsurer, agent, or independent claims administrator acting on behalf of GMS.

We may disclose a member or *dependent*'s information to a person who seeks the information as an authorized representative of the member or *dependent* (e.g., lawyer, power of attorney, etc.).

We may disclose a member or *dependent*'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.

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 *employees* in our organization, subcontracted *employees* 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.

We keep *your* information as long as allowed or permitted by law in accordance with our Records Retention and Destruction Policy.

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*.

For further information, please refer to GMS's privacy policy available at www.gms.ca.

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:
GMS
2055 Albert Street PO Box 1949
Regina, SK S4P 0E3