Benefits Booklet

Saskatchewan Retirees Association

GMS Plan #282368

Effective July 1, 2007
Revised October 1, 2017

Policy Year July 1 – June 30

HEALTH & TRAVEL INSURANCE | GROUP BENEFITS

GMS

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INTRODUCTION

WELCOME!

On behalf of Group Medical Services, we would like to welcome you as our client. As a Saskatchewan based non-profit company operating for over 60 years, we assure you that you will receive the best services and claims administration available. We hope you will find the information contained in this booklet useful. However, if you should need any further clarification, please call Group Medical Services head office at (306) 352-7638 or toll free at 1-800-667-3699.

Sincerely,

Group Medical Services

Please Note:

The purpose of this booklet is to summarize the main provisions of the master group policy. While every effort has been made to ensure the accuracy of this booklet, your rights and benefits are governed by the terms of the Master Group Benefits Policy.

Requests for information about coverage and questions about member benefits should be directed through your plan administrator.

Possession of this booklet alone does not mean that you or your dependants are automatically insured. The applicable group policy must be in effect and all of the eligibility requirements must be satisfied.

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

The master policy *GMS #282368* issued by Group Medical Services to *Saskatchewan Retirees Association* shall be the final basis for the settlement of all claims. Where there is a discrepancy or conflict between the description in this booklet and the master policy, the terms and conditions of the master policy prevail.

DEFINITIONS

"Accidental" – means a happening due to external, sudden, fortuitous causes beyond the member's or dependant's control.

"Anniversary Date" – means the annual recurrence of the original date of issue of the policy.

"Benefit Effective Date" – means the date a benefit becomes effective following any waiting periods that may apply.

"Child" – means a member's son or daughter, either natural or adopted, and includes the son or daughter of the person's spouse, or a foster child, as defined by provincial legislation.

"Couple Policy" – means a policy covering a member and one (1) eligible dependant.

"Dental Fee Schedule" – means the current Dental Association Fee Guide, of the province in which the member resides, including amounts listed for licensed specialist services. GMS has adopted a dental fee guide for those provinces that do not have their own.

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

"Dependant" – means

a) the member's spouse, defined to be the member's legal spouse by virtue of a religious or civil marriage or a person who has been residing with the member continuously for at least one (1) year and who has been publicly maintained and represented by the member as the member's spouse;
b) any unmarried child of the member or spouse (including step-child, adopted child or foster child):
    1) under twenty-one (21) years of age and not working more than thirty (30) hours per week, unless a full-time student;
    2) twenty-five (25) years of age and under 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
    3) 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 to ensure continuing eligibility (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).

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

"Endorsement" – means any endorsement attached hereto or which is included with, or added subsequently to, the execution of the agreement between GMS and the policy holder.

"Family Policy" – means a policy covering a member and two (2) or more eligible dependants.

"Formulary Drugs" – means the therapeutically effective drugs of proven high quality that have been approved for coverage under the Saskatchewan Drug Plan.

"GMS" – means Group Medical Services and/or its representatives, affiliates or other service providers.

"Government Plan" or "Government Health Insurance Plan" – means any plan of insurance provided by, regulated by or under the administrative control of any government or agency in accordance with any law (other than the Employment Insurance Act of Canada), or any plan providing insurance coverage regulated by any government.

"Hospital" – means an institution licensed as a Hospital, which is primarily engaged in providing medical, diagnostic and surgical services for the care and Treatment of sick or injured persons on an in-patient basis, and, which has a laboratory, a registered graduate nurse and a Physician always on duty and an operating room where surgical operations are performed by a legally licensed medical Physician(s). In no event will the term "Hospital" or "general active Treatment Hospital" mean any Hospital or institution or part of such Hospital or institution or used primarily as a clinic, continued care or extended care facility, convalescent home, rehabilitation centre, nursing home for the aged or Treatment centre for drug addiction or alcoholism.

"Immediately Related" – means a spouse, mother, father, sister, brother, child, grandchild, mother-in-law, father-in-law, sister-in-law, brother-in-law, son-in-law, daughter-in-law, and the spouse or child of a grandchild.

"Member" – means a person holding a membership in the SRA and meeting the eligibility requirements of the policy. Any person who is covered by this policy as a member may not be covered as a dependant. The surviving spouse of a member, who meets eligibility requirements of this policy, shall be deemed to be a member, provided that membership in the SRA is continued.

"Non-Formulary Drugs" – means the therapeutically effective drugs of proven high quality that require a written prescription from a physician, must be supplied by a licensed pharmacy, and the cost is **not** approved for coverage under the Saskatchewan Drug Plan.

"Non-adherence" means the failure or refusal of a patient to cooperate by carrying out that portion of the medical care plan under his or her control.

"Ophthalmologist" – means a physician who specializes in the treatment of disorders of the eye.

"Physician" – means a duly qualified doctor of medicine, who is not Immediately Related to the Member, and is entitled under the laws of the Province, State or Country where the services are rendered to practice medicine and surgery without restriction. A Physician does not include a naturopath, herbalist, or homeopath.

"Policy Holder" – means the employer or duly authorized representative of the employer.

"Policy Year" – means the twelve (12) months following the anniversary date of the policy.

"Province of Residence" – means the province that a member has declared as their permanent residence and resides in for a minimum of one hundred eighty (180) days per calendar year.

"Reasonable and Customary" – means charges that are comparable to those normally charged for that service in the particular area where the service is provided.

"Single Policy" – means a policy covering a member without dependants.

"SRA" – means the Saskatchewan Retirees Association.

"Stable" means any medical condition or related medical condition for which:

a) there have been no new symptoms, more frequent or more severe symptoms;
b) there has been no change in Treatment or change in medication (*);
c) there has been no deterioration of Your medical condition;
d) there has been no hospitalization or referrals to a specialist including initial follow-up visits, tests or investigations booked in conjunction with a medical condition/symptom;
e) there is no further testing, Treatment or investigation booked or results pending;
f) You have not experienced a symptom that remains undiagnosed;
g) no further medical Treatment after departure would be anticipated.

*Any newly prescribed medication, change in medication type, increase/decrease in dosage or discontinuation of a medication constitutes a change. It does not include a change from a brand name

medication to a generic brand medication of the same dosage. If you are taking Coumadin/Warfarin or anticoagulation therapy or are insulin dependent or take oral medication for diabetes and are required to have your blood levels tested on a regular basis and your medical condition remains unchanged, yet you are required to adjust the dosage of your medication only to ensure correct blood levels are maintained, this is not considered a change in medication, except for an adjustment (stop and start) in an anticoagulation medication dosage due to surgery within ten (10) days prior to your departure date constitutes a change.

"Surgeon" – means a physician who practices surgery.

"Treatment" – means 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 treatment directly referable to the condition, symptom or problem.

SCHEDULE OF BENEFITS

EXTENDED HEALTH CARE BENEFITS

This Schedule of Benefits forms part of this booklet and must be read in conjunction with the rest of this booklet.

IN CANADA

Overall Benefit Maximum:	$10,000 per person per Policy Year.

Extended Health Care Benefit Maximums:

✓	Prescription Drugs	100% $1,700 per Policy Year
	Per prescription deductible	Equivalent to dispensing fee
✓	Vision	
	Eyeglasses/contact lenses	80% $300 per 2 Policy Years**
	Eye exams	80% $125 per Policy Year**
✓	Road Ambulance	100% Unlimited*
✓	Air Ambulance	100% Unlimited*
✓	Private Duty Nursing	80% $5,000 per Policy Year
✓	Preferred Hospital Room	100% Unlimited
✓	Accidental Injury to Natural Teeth	100% $2,000 per Policy Year
✓	Health Practitioners	80% $300 per specialty per Policy Year
✓	Casts and Crutches	80% Unlimited
✓	Patient Walkers	80% $300 per 3 Policy Years
✓	Artificial Eyes, Limbs and Larynx	80% Unlimited
✓	Wheelchairs, Scooters and Adjustable Beds	80% $500 per 5 Policy Years
✓	Diabetic Supplies	100% Unlimited
✓	Diabetic Equipment	100% $500 per 5 Policy Years, 1 per person
✓	Ostomy Supplies	80% Unlimited
✓	Oxygen Equipment	80% $500 per Policy Year
✓	Breast Prosthesis	80% Unlimited
	Surgical bras	80% 2 per Policy Year
✓	Custom Foot Orthotics	80% 1 pair per 3 Policy Years, up to $400
✓	Therapeutic Shoes	80% $200 per Policy Year
✓	Hearing Aids	80% $800 per 3 Policy Years**
✓	Blood Pressure Monitors	80% 1 per 5 Policy Years
✓	Cardiac Rehabilitation	80% $225 per Policy Year
✓	Out of Province Referral	80% $50,000 Lifetime Maximum*
✓	Other Health Benefits	80% $500 combined per Policy Year
	Embolic stockings	80% 4 per Policy Year

*All benefits are eligible within Canada unless otherwise indicated. Please read the full benefit descriptions for more details.

****Vision and Hearing Aid benefits are currently the only two benefits listed above that will be considered for reimbursement if purchased online or out-of-Canada.**

OUT-OF-PROVINCE/CANADA

This Schedule of Benefits forms part of this booklet and must be read in conjunction with the rest of this booklet.

Emergency Out-of-Province/Canada:	$1,000,000*
Maximum Out-of-Province Duration:	180 days
Maximum Out-of-Canada Duration:	60 days
Stability Clause:	90 or 180 days**

** You, or someone on your behalf, must contact our designated travel assistance firm prior to treatment whenever possible and in any event within twenty-four (24) hours of medical treatment or admission to hospital. Failure to contact our designated travel assistance firm within twenty-four (24) hours of medical treatment or admission to hospital will result in restricted coverage under the policy, otherwise payable to you, to 70% of eligible charges to a maximum of $50,000.*

For members under seventy-five (75) years of age:

*** GMS will not provide coverage for the treatment, recurrence or complications relating directly or indirectly to a medical condition which was consulted for, treated or investigated during the **ninety (90)** day period immediately before the effective date of travel coverage. A medical condition is covered if it is controlled by the consistent use of medications prescribed by a physician, provided that, during the **ninety (90)** day period prior to the travel coverage effective date, there has been no other treatment, no deterioration of that medical condition, no new, more frequent or more severe symptoms for that medical condition, no change in medication (a new medication or increase/decrease in dosage constitutes a change) and no medical attention after departure would be reasonably anticipated.*

For members age seventy-five (75) years and over:

*** GMS will not provide coverage for the treatment, recurrence or complications relating directly or indirectly to a medical condition which was consulted for, treated or investigated during the **one hundred and eighty (180)** day period immediately before the effective date of travel coverage. A medical condition is covered if it is controlled by the consistent use of medications prescribed by a physician, provided that, during the **one hundred and eighty (180)** day period prior to the travel coverage effective date, there has been no other treatment, no deterioration of that medical condition, no new, more frequent or more severe symptoms for that medical condition, no change in medication (a new medication or increase/decrease in dosage constitutes a change) and no medical attention after departure would be reasonably anticipated.*

Extended Health Care Travel Benefits and Maximums:

✓ Hospitalization	Unlimited *
✓ Physicians and Surgeons	Unlimited *
✓ Health Practitioners	$300 combined per Policy Year
✓ Private Duty Nursing	Unlimited *
✓ Emergency Transport	Unlimited *
✓ In-Flight Medical Attendant	Unlimited *
✓ Accidental Injury To Natural Teeth	$1,000 per Policy Year
✓ Prescription Drugs	$300 per Policy Year
✓ Return of Remains	Unlimited *
✓ Vehicle Return	$1,000 per trip
✓ 24 Hour Travel Assistance	24 hour service

* These benefits are each payable to an unlimited maximum, but cannot exceed the overall Emergency Out-of-Province/Canada maximum when combined with all other Extended Health Care Travel benefits.

24-Hour Travel Assistance Services

The emergency medical travel coverage includes travel assistance services for members.

Our travel assistance service will provide the following services anywhere in the world:

- obtain medical treatment
- co-ordinate medical care and transportation
- verify coverage and provide support in areas of foreign languages

For Emergency Assistance Call:

Toll Free: **1-800-459-6604 (Canada or U.S.)**
Collect: **(905) 762 5196 (elsewhere)**

*** When travelling outside of Canada, members and/or covered dependants must return to Canada prior to making a subsequent trip outside of Canada when the maximum trip length allowable under the plan is reached, before benefit coverage will be provided for subsequent trips. Each of the benefit conditions and exclusions, including the ninety (90) or one hundred and eighty (180) day stability clause, pertains to each subsequent trip taken.*

DENTAL CARE BENEFITS

This Schedule of Benefits forms part of this booklet and must be read in conjunction with the rest of this booklet.

Dental Limitations: Members must purchase a health plan in order to be eligible to purchase a dental plan.

Dental Care Benefit Maximum: $1,200 combined per person per Policy Year

✓	Preventative and Basic Services	**80%**
✓	Major Dental Services	**50%**

NOTE: The Extended Health, Dental and Travel Plan is insured by Group Medical Services

GENERAL INFORMATION

SRA MEMBERSHIP APPLICATION

To participate in the SRA Health & Dental Benefits Plan, you must be a member of the SRA. The registration is a one-time fee of $25. Please contact the SRA office at (306) 584-5552 for details and requirements of becoming a member of the association.
The SRA must approve and sponsor your SRA membership application before your application for the SRA Health & Dental Benefits Plan can be processed. Please forward your SRA Membership Application, initiation fee, and your GMS application for the SRA Health & Dental Benefits Plan to:
Saskatchewan Retirees Association
Walter Scott Building
3085 Albert Street
Regina, SK S4S 0B1

ELIGIBILITY

Who is eligible to enroll?

Eligibility of a member

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

- a retiree of government/crowns,
- a member of the SRA, and
- insured under a provincial government health insurance plan.

You must apply for this plan within sixty (60) days of the latest of the following dates:

- the date the member is retiring from active work (and therefore losing coverage under the employer group plan) or otherwise becomes eligible to receive a pension, as an employee or surviving spouse of an employee; or
- the date of cancellation of coverage under the spouse's group plan.

If applying more than sixty (60) days after the latest of the dates listed above, the member will be required to provide medical evidence satisfactory to GMS, and may be subject to medical underwriting and prior approval of GMS.

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 a minimum of one hundred and eighty (180) days each calendar year.

Eligibility of a 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 the definitions of this booklet.

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. If this information is not received within thirty-one (31) days of being eligible for coverage, the dependant will be required to provide medical evidence satisfactory to GMS, and may be subject to medical underwriting and prior approval of GMS.

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 21, 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 a minimum of one hundred and eighty (180) days each calendar year.

No dependant shall be covered under the health plan unless the member is simultaneously covered under the health plan. No dependant shall be covered under the dental plan unless the member is simultaneously covered under the dental plan.

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 Application/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. This is an annual plan. The renewal date is July 1st of each year.

Dependant's effective date

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

- the date your coverage begins, or
- 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;
c) the date on which your age is over the specified age in the Schedule of Benefits under each benefit; or
d) the date on which you no longer meet the definition of a member, as provided by this plan.

A member may terminate their coverage only at renewal.

If a member quits the health plan, they can rejoin at a later date subject to the approval or denial of a medical questionnaire. If a member cancels the dental plan, they cannot rejoin at a later date.

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; or
c) the end of the period for which premiums have been paid.

In the event of death of the member, Group Medical Services will continue the Extended Health Care and Dental Care benefits without payment of premium for the dependants until the earliest of:

a) the date the dependant no longer meets the definition of a dependant;
b) the date similar coverage is obtained elsewhere;
c) July 1st following the death of the member; or
d) the date which the group policy terminates.

Dependants may continue on the plan if they begin to pay premiums again after the balance of the Policy Year has expired and they continue to meet eligibility requirements.

What if I have comparable coverage under my spouse's extended health care plan?

If you are insured under your spouse's health plan at the time of application, you may waive comparable extended health coverage offered by this plan. Should you wish to join the plan at a later date, proof of previous coverage will be required.

In the meantime, according to Coordination of Benefit guidelines, after the government plans and your spouse's plans have been determined, the excess benefits may be coordinated with those of other policies.

Benefits payable from all plans will not exceed 100% of the actual allowable expenses.

Example:

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

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

UPDATING RECORDS

To ensure that coverage is kept up-to-date for you and your dependants, it is vital that you advise GMS of any changes. This includes a name change, change in marital status or dependants, or application for benefits previously waived.

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 dependants for similar benefits. After the benefits of the government plans 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 members and their spouses, 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 group plan where the insured person is covered;
b) if a person is a member of two plans, priority goes to:
    i.) the group plan where the Member is an active full-time Employee;
    ii.) the group plan where the Member is an active part-time Employee;
    iii.) the group plan where the Member is a retiree;
c) the group plan where the person is covered as a Dependant spouse;
d) the private plan (Individual Health Plan) where the insured person is covered.

Dependant Children

e) the group plan of the parent with the earlier birthdate (month/day) in the calendar year;
f) the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate;
g) in situations where parents are separated/divorced, then the following order applies;
    i.) the group plan of the parent with custody of the child;
    ii.) the group plan of the spouse of the parent with custody of the child;
    iii.) the group plan of the parent not having custody of the child; or
    iv.) the group plan of the spouse of the parent not having custody of the child.
h) the private plan (Individual Health Plan) where the insured person is covered.

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 order of benefit payment section, determine which plan is the primary carrier and which is the secondary carrier. Your group 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 or ask the primary carrier to return the original receipts to you once your claim has been settled.
- 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.

PAY-DIRECT DRUG AND DENTAL CARD

Your Pay-Direct Card contains your Group Medical Services (GMS) and prescription drug/dental identification number for the individuals covered by the plan.

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.

Since there are numerous providers throughout the province, not all of them will be familiar with the Group Medical Services Pay-Direct card. The numbers must be entered exactly as they appear on the card.

If your spouse has coverage under another plan, submission of receipts must be made to that plan first. GMS will reimburse balance amounts not paid by the other carrier. If you have dependent children, the parent with the earlier birth date will submit the claims to their plan.

PAYMENT OF PREMIUMS

How are premiums paid?

To help finance the annual premium of the plan, Group Medical Services offers SRA members the option of paying their premiums through monthly automatic bank deductions (pre-authorized payments). Monthly premium payments are deducted on the first or fifteenth banking day of each month. As well, premiums may also be paid by an annual lump sum payment in advance.

Your plan option (i.e. Single, Couple, Family) at enrolment, or subsequently on renewal, determines your minimum premium payments for the entire Policy Year.

The first premium is due and payable on the effective date of each Member and monthly premiums are due and payable in advance, on the first day of each month thereafter during the continuance of this Policy. All premiums are payable by the Member at the office of GMS. The plan option of a Member (i.e., Single, Couple, Family) at enrollment, or subsequently on renewal, determines the minimum premium payments for that Member for the entire Policy Year. In the event that a Member's option is downgraded during the year (e.g., Couple to Single, Family to Couple, Family to Single), the policy will be downgraded and any required adjustment to the premium level will be effective the first of the month following receipt of the request to downgrade. If a plan option is downgraded due to the death of a Dependant, the premium will change the first of the month following the date of death.

In the event that your option is upgraded during the year (e.g. Single to Couple, Couple to Family), the rate for the upgraded option takes effect immediately and will remain in effect for the remainder of the entire Policy Year.

PAYMENT OF CLAIMS

How and where do I submit a claim for extended health and dental benefits?

In order for Group Medical Services to pay **extended health care** benefits, submit a completed Group Medical Services Extended Health Care Plan Claim Form and the original receipts with the following

information: Group Medical Services identification number, patient name, address and phone number, date and details of service and physician referrals where required.

In order for Group Medical Services to pay **dental care** benefits, submit a Group Medical Services Dental Claim Form or a standard dental claim form.

Claim forms are available through your plan administrator, Group Medical Services or on the Group Medical Services website at www.gms.ca.

Group Medical Services does not return receipts, so be sure to make copies of the receipts if you require them to co-ordinate claims with other carriers or for income tax purposes.

Claims can be mailed to or dropped off at Group Medical Services' head office:

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

NOTICE OF CLAIMS

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, members must submit any claim to Group Medical Services within thirty (30) days following the date of termination of the policy.

EXTENDED HEALTH CARE BENEFITS

The following benefits are payable resulting from injury or illness which is not assumed under a province's basic medical plan. Coverage is per Policy Year with limits payable per person, unless otherwise stated.

IN CANADA

*Please note some benefit provisions may be limited to within the member's province of residence.

When eligible expenses are incurred outside of their province of residence, GMS will cover the Reasonable and Customary charges for the following benefits, in excess of the amount permitted and/or paid by the government health insurance plan and/or any other insurance plans.

Prescription Drugs

Payment for formulary and non-formulary prescription drugs not otherwise covered under the subscriber's provincial drug plan, which require a written prescription from a physician.

All claims for prescription drugs must first be submitted to your provincial drug plan for eligibility. In order to ensure proper coordination with the member's provincial health plan, the member, when requested, may be required to apply for any and all support or coverage programs that may exist or may come to exist. GMS coverage applies after the benefits of the government plans, including but not necessarily limited to the provincial drug plan, have been determined. Generic substitutions may be used to replace brand name prescription drugs, unless "no substitutions" is specifically indicated by the physician.

This benefit excludes fertility drugs, drugs intended for the treatment of sexual dysfunction, lifestyle drugs, experimental drugs, diet drugs, drugs used for cosmetic purposes, drugs normally available over the counter and drugs for the cessation of smoking.

Vision

Payment for eyeglasses and/or contact lenses when provided on the written prescription of a medical doctor or optometrist.

Payment for eye examinations and services, including refractions, rendered by an optometrist or an ophthalmologist.

This benefit includes payment for glasses and/or contact lenses purchased online or out-of-Canada.

This benefit excludes payment for sunglasses (prescription or non-prescription) and eyeglasses for cosmetic purposes.

Road Ambulance

Payment for the transport of emergency cases to the nearest hospital or health centre equipped to provide emergency treatment.

*50% payment for the return of bedridden cases to the place of permanent residence, provided transport is within the patient's province of residence.

This benefit excludes payment for transportation to physician's offices and medical clinics.

*Air Ambulance

Payment for the transport, within your province of residence, of emergency cases by your provincial government air ambulance, of emergency cases when authorized by a physician.

Private Duty Nursing

Payment for private duty nursing charges in-hospital or in-home as palliative care by a registered nurse or a licensed practical nurse who is not immediately related to the patient or does not normally reside in the patient's home when ordered in writing by a physician.

In-home services must commence immediately following release from hospital and must be consistent with the treatment of the condition for which the patient was hospitalized.

This benefit excludes nursing benefits rendered in licensed institutional type facilities.

Preferred Hospital Room

Payment for private or semi-private hospital room charges.

This benefit excludes convalescent and respite care.

Accidental Injury to Natural Teeth

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

The injury must be reported to GMS within six (6) months of the accident. This benefit excludes dental implants.

Health Practitioners

Payment of the charges for chiropractic, podiatry, clinical psychology, massage therapy, acupuncture, speech therapy and physiotherapy treatments provided by a health practitioner who is a current member of a professional association recognized by GMS.

Treatments by a massage therapist require written referral of a physician.

All treatments must be provided by a practitioner not immediately related to the patient.

Casts and Crutches

Payment for the charges for fiberglass casts and for the purchase or rental of crutches.

Patient Walkers

Payment of the charges for the rental of, or when approved by GMS, the purchase of, patient walkers when ordered in writing by a physician.

Artificial Eyes, Limbs and Larynx

Payment for an artificial eye, an artificial limb or an artificial larynx.

Wheelchairs, Motorized Scooters and Adjustable Beds

Payment for the rental of, or when approved by GMS, the purchase of, wheelchairs, motorized scooters and/or adjustable beds, when ordered in writing by a physician.

This benefit excludes adjustable beds for individuals confined to, or resident in, an active treatment hospital, a convalescent facility, a nursing home or a personal care home.

This benefit's maximum, as stated in the schedule of benefits, is payable per policy, not per person.

Diabetic Supplies and Equipment

Payment for the purchase of diabetic supplies and equipment, including testing devices when ordered by a physician for use in the home. Insulin infusion sets are eligible for payment, but Insulin pumps are not eligible. This benefit excludes insulin and other prescription medications.

Diabetic supplies are payable with the GMS Pay-Direct Drug Card.

Oxygen Equipment

Payment for the rental of, or when approved by GMS, the purchase of, oxygen equipment and/or Continuous Positive Airway Pressure (CPAP) supplies when ordered by a physician for use in the home and the cost of oxygen.

This benefit excludes the cost of CPAP machines.

Ostomy Supplies

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

Breast Prosthesis

Payment for the purchase of artificial breast prosthesis and surgical bras for mastectomy patients. A written physician's referral is required for mastectomy patients.

Custom Foot Orthotics

Payment for the purchase of custom made foot orthotics by an accredited podiatric biomechanics laboratory.

The orthotic must be created by using a 3-dimensional impressing technique or a 3-dimensional model of the foot and be made from raw materials.

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

Therapeutic Shoes

Payment for the purchase, repair, or replacement of therapeutic shoes customized for a specific foot condition.

A written prescription, including a medical diagnosis of a foot condition is required from an orthopedic surgeon, a podiatrist, or an attending physician.

The shoe must be custom built or specifically designed or melded for the covered person, and supplied by a certified pedorthist, orthotist, or chiropodist/podiatrist. The receipt must be completely itemized, with the type of shoe including all modifications done.

This benefit excludes payment for sandals, runners, and boots/shoes with trends or fashion that have pointed toes.

Hearing Aids

Payment for a hearing aid, when fitted by an audiologist or when an audiogram is conducted by an audiologist.

This benefit includes payment for hearing aids purchased online or out-of-Canada.

This benefit excludes payment for hearing tests, hearing aid fitting services, batteries, repairs and additional and/or replacement ear moulds.

Blood Pressure Monitors

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

This benefit's maximum, as stated in the schedule of benefits, is payable per policy, not per person.

Cardiac Rehabilitation

Payment for treatment rendered to a cardiac patient under a recognized cardiac rehabilitation program where treatments have been prescribed by the attending physician for rehabilitation after myocardial infarction, coronary bypass surgery or valve replacement; or for the management of angina pectoris or other diagnosed cardiac disease.

*Out of Province Referral

Payment for the charges of physician, anaesthetic, radiology, laboratory, hospital and ambulance services, for treatment which is not available in your province of residence, when recommended by a specialist.

The claim must have prior written approval from GMS.

This benefit excludes payment for any condition that existed in the twelve (12) months prior to the effective date of coverage. Referrals for services that are outside of Canada are excluded from this benefit.

Other Health Benefits

Payment for the purchase or rental of splints, wigs, braces with metal components, trusses, rib belts, air casts, clavicle straps, shoulder immobilizers, cervical collars, sacroiliac corsets, embolic stockings, aero chambers, and compressors.

All items require a written prescription from a physician.

EXTENDED HEALTH CARE BENEFITS AND EXCLUSIONS

1. GMS reserves the right to determine which drugs, new to the marketplace, will be eligible for reimbursement.
2. GMS reserves the right to determine which Health Practitioner Associations will be eligible for reimbursement.
3. Benefits are payable only for amounts in excess of what would normally be payable under government plans as they exist as of the effective date of the policy.
4. Neither GMS nor our designated travel assistance firm are responsible for the availability, quality, results of any medical treatment or transportation or your failure to obtain medical treatment.
5. No benefit will be provided that is a duplication of any service, allowance or reimbursement supplied by an existing government or private plan.
6. No benefit will be provided for expenses directly or indirectly from the commission or attempted commission of any criminal, criminal-like or illegal activity; intentional self-injury, suicide or attempted suicide; the abuse of medication, drugs or alcohol; mental, emotional, nervous or psychological disorders; any participation in the armed forces; or any willful exposure to peril.
7. No benefit will be provided for expenses incurred as a result of a motor vehicle accident, unless such services are not covered by any other private or public vehicle insurance.

8. No benefit will be provided for expenses resulting from participation in professional sports, any speed contest, SCUBA diving (unless PADI, ACUC or SSI certified), rodeo, parachuting, mountaineering, skydiving, hang gliding, bungee cord jumping, acrobatic or stunt flying, or a flight accident unless as a passenger on a commercially licensed airline.

EXTENDED HEALTH CARE TRAVEL BENEFITS

IMPORTANT NOTICE
PLEASE READ CAREFULLY

- Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your booklet before you travel as your coverage may be subject to certain limitations or exclusions.
- A pre-existing exclusion applies to medical conditions and/or symptoms that existed prior to your trip. Check to see if this applies to you and how it relates to your departure date.
- In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is reported.
- You are required to notify our designated travel assistance company prior to treatment, where possible, and no later than 24 hours after receiving medical treatment or being admitted to hospital.

PLEASE READ YOUR BOOKLET CAREFULLY
BEFORE YOU TRAVEL

Emergency Medical Travel Coverage

- **$1,000,000 maximum per person per lifetime**
  GMS includes coverage for **emergency medical expenses** incurred due to sudden or unexpected illness or accidental bodily injury while traveling outside of your province of residence or Canada.

Maximum trip duration

- **60 days of coverage for travel outside of Canada**
  GMS protects the member and/or his/her eligible dependants for an unlimited number of trips per year to a maximum duration of sixty (60) days per trip.

  For the expenses to be eligible, the necessary diagnosis and treatment must occur within the first sixty (60) days of leaving Canada.

- **180 days of coverage for travel inside of Canada**
  For the expenses to be eligible, the necessary diagnosis and treatment must occur within the first one hundred and eighty (180) days after leaving your province of residence if remaining in Canada.

Restriction for Pre-Existing Conditions

- **For members under age seventy-five (75):**
  Coverage for medical conditions that existed prior to the departure from your province of residence is subject to the following:
  - The policy will not provide coverage for the treatment, recurrence or complications relating directly or indirectly to: a medical condition or symptom(s) which was consulted for, treated or investigated during the ninety (90) day period immediately before the date of departure from your province of residence or for which you are awaiting further treatment or investigation; or a medical condition or symptom(s) for which medical attention after departure would be reasonably anticipated.
  - However, a medical condition is covered if it is controlled by the consistent use of medications prescribed by a physician, provided that, during the entire ninety (90) day period prior to the date of departure from your province of residence: there has been no change in medication (a new medication or increase/decrease in dosage constitutes a change); there has been no other treatment; there has been no deterioration of that medical condition; and there has been no new, more frequent or more severe symptoms for that medical condition.

- **For members age seventy-five (75) and over:**
  Coverage for medical conditions that existed prior to the departure from your province of residence is subject to the following:
  - The policy will not provide coverage for the treatment, recurrence or complications relating directly or indirectly to: a medical condition or symptom(s) which was consulted for, treated or investigated during the one hundred eighty (180) day period immediately before the date of departure from your province of residence or for which you are awaiting further treatment or investigation; or a medical condition or symptom(s) for which medical attention after departure would be reasonably anticipated.
  - However, a medical condition is covered if it is controlled by the consistent use of medications prescribed by a physician, provided that, during the entire one hundred eighty (180) day period prior to the date of departure from your province of residence: there has been no change in medication (a new medication or increase/decrease in dosage constitutes a change); there has been no other treatment; there has been no deterioration of that medical condition; and there has been no new, more frequent or more severe symptoms for that medical condition.

OUT-OF-PROVINCE/CANADA

GMS will cover the reasonable and customary charges for the following benefits, in excess of the amount reimbursed by the government health insurance plan and/or any other insurance plans:

Hospitalization

Payment for Hospital accommodations up to semi-private rooms and hospital services and supplies necessary for the emergency care during hospitalization. One follow-up visit (excluding on-going treatment) is covered in situations where the medical process in dealing with the emergency requires such a follow-up visit. The follow-up visit must take place within (14) days of the initial emergency.

Physicians and Surgeons

Payment for emergency services of a physician or surgeon for diagnosis and treatment of an acute illness or injury.

Health Practitioners

Payment for emergency services of a physiotherapist, chiropractor, osteopath, podiatrist and/or chiropodist.

Private Duty Nursing

Payment for private duty nursing in a hospital during an emergency by a registered nurse, who is not immediately related to the patient or does not reside with the patient, when ordered by a physician or surgeon.

Emergency Transport

Payment for a licensed road ambulance for emergency transport to the nearest hospital where adequate facilities are available.

Payment for an air ambulance or regular scheduled airline for emergency transport back to Canada for further in-hospital treatment when recommended in writing by a physician and with prior approval of GMS.

This benefit does not include transportation within Canada, and excludes helicopter transports.

In-flight Medical Attendant

When recommended in writing by a physician, GMS will reimburse the cost of one return trip economy fare for a qualified medical attendant who is not a friend, relative, associate, or traveling companion of the patient to accompany you home.

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 wittingly or unwittingly placed in the mouth.

This benefit excludes dental implants.

Prescription Drugs

Payment for drugs and medication when obtained on the prescription of the attending physician and supplied by a licensed pharmacist as a result of an emergency medical condition.

Return of Remains

Payment of charges for the homeward carriage of a deceased member or covered dependant.

Vehicle Return

Payment for the cost of returning your vehicle, either private or rental, to your province of residence or nearest appropriate vehicle rental agency, when you or your traveling companion are unable to do so due to unexpected illness or accidental physical injury. This benefit is only available when GMS returns you to your province of residence for further in-hospital medical treatment. Written medical certification and paid receipts for the costs incurred are required.

OUT-OF-PROVINCE/CANADA BENEFIT CONDITIONS AND EXCLUSIONS

1. It is the responsibility of the member to provide proof that dates of travel are consistent with the terms of the policy.
2. When traveling outside of Canada, members and/or covered dependants must return to Canada prior to making a subsequent trip outside of Canada when the maximum trip length allowable under the plan is reached, before benefit coverage will be provided for subsequent trips. Each of the benefit conditions and exclusions, including the ninety (90) or one hundred and eighty-day (180) stability clause, pertains to each subsequent trip taken.
3. No benefit will be provided where the patient acts against medical advice or the advice of GMS and/or our designated travel assistance firm.
4. No benefit will be provided for any treatment, hospitalization or surgery (including elective, non-elective, personal comfort, dental or cosmetic) which is not considered to be an emergency, even if it is recommended by a physician.
5. No benefit will be provided for treatment at a diagnostic facility unless pre-approved by our designated travel assistance firm.
6. Emergency air transportation or return to your province of residence must be arranged by our designated travel assistance firm.
7. No benefit will be provided for routine or general physical examinations, check-ups or services of a continued nature following emergency treatment of a sickness or injury.
8. No benefit will be provided 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.
9. No benefit will be provided for any advice, investigation, treatment, hospitalization or surgery, which is a continuation of, subsequent to, or a recurrence of an emergency medical treatment of a sickness or injury, when medical evidence shows that you were able to safely return to your province of residence, for treatment of that condition.
10. No benefit will be provided for expense resulting when travel is booked or commenced contrary to medical advice.
11. No benefit will be provided for any services or expenses incurred when a journey is undertaken for the purpose or with the intent of securing medical or surgical diagnosis or treatment.
12. No benefit will be provided for pregnancy, miscarriage, childbirth or complications of any of these conditions occurring after the first eighteen (18) weeks of pregnancy.
13. No benefit will be provided for coronary artery angioplasty, cardiac surgery or implantable cardiac defibrillators (including any associated diagnostic tests or charges), unless necessary in a medical emergency and approved by GMS prior to any actions.
14. No benefit will be provided for any endovascular surgical procedures, either done individually or in combination with conventional surgical procedures.
15. No benefit will be provided for any treatment or surgery which is considered, by GMS to be experimental and GMS's opinion on the issue is final and binding.
16. No benefit will be provided for treatment or services that contravene or are prohibited by the provincial laws of the member's province of residence and the federal laws of Canada that apply in your province of residence.

17. No benefit will be provided for persons holding a work visa from the country to which they are travelling; or for persons working in hazardous occupations, as deemed by GMS, such as mining or oil exploration.
18. If eligible expenses are incurred due to the fault of a third party, GMS may take legal action against the faulty party in your name. This requires your full cooperation in providing GMS any necessary information.
19. GMS, in consultation with the attending physician, reserves the right to transfer the patient to another hospital or medical facility capable of providing the necessary medical services or to return the patient to their province of residence. Refusal to do so by the patient will absolve GMS of further liability.
20. GMS and/or our designated travel assistance firm have the authority to access prior and/or resulting medical records or reports, covering diagnosis and services rendered to covered persons, from any physician, hospital, medical clinic, any other medical care facility or any government insurance plan.
21. Any material misrepresentation, provision of incorrect information or non-disclosure of information, related to medical conditions, will result in non-payment of any related claims.
22. Benefits are payable only for amounts in excess of what would normally be payable under government plans as they exist as of the effective date of the policy.
23. No benefit will be provided that is a duplication of any service, allowance or reimbursement supplied by an existing government or private plan.
24. No payment will be provided for expenses resulting directly or indirectly from the commission or attempted commission of any criminal, criminal-like or illegal activity; intentional self-injury, suicide or attempted suicide; the consumption or abuse of any alcohol, medication or drugs, or any event, act or omission caused or contributed to by the use or abuse of alcohol, medication or drugs; any participation in the armed forces; or any willful exposure to peril.
25. No benefit will be provided for expenses incurred as a result of a motor vehicle accident, unless such services are not covered by any other private or public vehicle insurance.
26. No benefit will be provided for expenses resulting from participation in professional sports, any speed contest, SCUBA diving (unless PADI, ACUC or SSI certified), rodeo, parachuting, mountaineering, skydiving, hang gliding, bungee cord jumping, acrobatic or stunt flying, or a flight accident unless as a passenger on a commercially licensed airline.
27. No benefit will be provided for expenses when you travel to a country after such time that a travel advisory has been issued by the Canadian government recommending that Canadians do not travel to such country, or to specific regions within such country.
28. No benefit will be provided for expenses resulting from the regular care of a chronic condition.
29. No benefit will be provided for expenses incurred as a result of non-adherence with medical treatment prior to departure.
30. No benefit will be provided for transplants at your destination, including but not limited to organ transplants, bone marrow or stem cell transplants.
31. GMS is not responsible for the availability, quality or results of any medical treatment or transportation or your failure to obtain medical treatment.

DENTAL CARE BENEFITS

The Dental Plan provides coverage for a member and covered dependants' dental expenses. Reimbursement of the following eligible expenses is based on the current Dental Fee Schedule.

The following provisions shall apply to the dental care plan:

- Services totalling $600 or more must have prior approval from GMS before the services are begun. If a dental pre-authorization is not submitted prior to commencement of services, benefits, otherwise payable, shall be limited to $600 for the services performed.
- If you or your covered dependants incur **emergency** dental treatment expenses while traveling outside your province of residence, the plan will reimburse you on the same basis as though the expenses were incurred in the province of Saskatchewan.
- Members must purchase a health plan in order to be eligible to purchase a dental plan.

Eligible dental expenses are payable to a combined maximum of $1,200 per person per Policy Year.

Preventative Dental Services – 80%

a) Coverage, based on units of time consisting of fifteen (15) minutes each, will allow up to ten (10) units of scaling (combined with periodontal root planing), two (2) units of polishing, and two (2) units of sodium or topical fluoride treatment per policy year.

b) Pit and fissure sealants (for dependent children under 18 years of age) once per tooth per lifetime.

c) Protective mouth guard appliances will be covered once per policy year for dependants under age sixteen (16) and once per three (3) policy years for individuals sixteen (16) years of age and over.

d) Provision of space maintainers to maintain, but not obtain space.

e) Occlusal adjustment and equilibration will be covered to four (4) units per person per policy year.

f) Interproximal disking of teeth.

a) Bruxism appliances, one per policy year for dependants under sixteen (16) years of age, and one per three (3) policy years for dependants sixteen (16) years of age and over.

Basic Dental Services – 80%

a) Complete dental examination, which would include history, medical and dental; clinical examination and diagnosis, once per person per three (3) policy years.

b) Limited oral examination procedures, including recall and specific examinations, shall be covered twice per person per policy year. Emergency examinations will be unlimited.

c) Intra-oral and extra-oral dental x-rays shall be covered to ten (10) films per person per two (2) policy years. A complete (full mouth) or panoramic series of x-rays shall be covered once per person per three (3) policy years.

d) Treatment planning and consultations.

e) Basic oral surgery including erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions and postsurgical care.

f) Basic restorations of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations and plastic restorations.

g) Endodontic Treatment for permanent teeth including Treatment of the pulp chamber, root canal therapy, periapical services, miscellaneous surgical services (root amputation, hemisection, replantation, and perforations) and miscellaneous Endodontic procedures (open and drain and non-vital bleaching). Root canal therapy is limited to once per tooth per five (5) policy years.

h) Diagnostic casts are covered once per person per three (3) policy years.

i) Anaesthetics administered in connection with oral surgery or other covered dental services.

j) Surgical periodontal services including gingival curettage, gigivoplasty, gingivectomy and flap approach. Each type of surgery is limited to once per site (sextant) per person per policy year.

k) Non-surgical periodontal services including management of oral disease and desensitization.

l) Periodontal root planing will be covered to ten (10) units (combined with scaling) per person per policy year.

m) Rebasing and relining of dentures will be covered once per person per three (3) policy years per arch.

n) Removable prosthodontics services including denture repairs and additions, tissue conditioning for dentures and miscellaneous denture service (resilient liner and resetting of teeth).

o) Fixed prosthodontic repairs including replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, recementation and fixed bridge/prosthesis repairs.

Major Dental Services – 50%

a) Inlays, onlays, crowns, and veneers are covered when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where significant areas of previous fillings and decay prevent the use of more traditional filling materials to adequately restore the tooth.

   The replacement of inlays, onlays, crowns and veneers must be separated by at least five (5) years.

b) Full and/or partial upper and lower dentures, including any necessary adjustments, limited to teeth extracted while covered under this plan to a maximum of one (1) per arch.

   The replacement of complete or partial dentures or bridges are limited to teeth extracted while covered under this plan, or provided the existing complete or partial denture and bridge are 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.

c) Denture adjustments are covered once per person per policy year.

Dental Benefit Conditions

1. The Policy covers only necessary and adequate dental services. The excess charges of alternate courses of Treatment over and above the charges for necessary and adequate dental service in the circumstances shall not be covered by the Policy and shall be the Insured Person's responsibility. Where there is any dispute as to necessary and adequate dental services, the reasonable determination of GMS shall be final.

2. GMS will not pay for the item classified as an "examination" in the Dental Fee Guide where the Dentist performs any other separately itemized Treatment, such as extraction, a filling, endodontic Treatment, periodontic Treatment or the provision of prosthetics or the construction of crowns, in instances where a prior "examination" has determined that the separately itemized Treatment is necessary.

3. GMS will cover standard cast chrome with external clasp retainers only or acrylic partial denture and where a more complicated or precision appliance is supplied, the extra cost is the responsibility of the Insured Person.

4. 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 the difference in cost will be the Insured Person's responsibility.

5. Only Dentists will be paid for x-rays.

6. 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 the Policy if the device was ordered, or the service for the device was started, before the person became covered by the Policy.

7. If there were three (3) or more teeth missing prior to the person becoming eligible for coverage under the Policy, then GMS will pay for a partial denture only.

8. Replacement of identical restorations will only be covered once every twelve (12) months.

9. GMS will pay for services and procedures only to the maximum amounts as provided for in your provincial Dental Fee Guide. Any charges over and above the Dental Fee Guide will be the Insured Person's responsibility.

Dental Exclusions

The following services or supplies are excluded from coverage from the Policy:

(a) Services or supplies for injuries or conditions which are compensable under Worker's Compensation Laws.

(b) Services or supplies which are provided by any Government Agency.

(c) Services or supplies associated with:

- Treatment performed for cosmetic purposes only,
- Congenital defects or developmental malformations or replacements of congenitally missing teeth, or
- Temporomandibular Joint disorders.

(d) Services or supplies for implantology, including tooth implantation, crowns, bridges and dentures involved in an implant procedure and surgical insertion of fabricated implants.

(e) Procedure, appliances or restorations used to increase vertical dimension and repair or restore teeth damaged or worn due to attrition or vertical wear.

(f) Periodontal appliances, unless specified as a covered benefit.

(g) Replacement of lost or stolen dentures or replacement/repair of orthodontic braces.

(h) Spare or duplicate prosthetic devices or appliances.

(i) Missed appointments.

(j) Completion of claim forms or pre-determinations.

(k) Instruction in dental hygiene.

(l) Nutritional counselling.

(m) Hypnosis.

(n) Prescribed drugs.

(o) Experimental procedures.

(p) Tissue grafts.

GROUP MEDICAL SERVICES 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.

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 hospitals, doctors and other health care providers, the government (including your provincial 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?
In the event one of our members, or their dependants, 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.

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 members in our organization, subcontracted members 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:

Group Medical Services
Attn: Chief Privacy Officer
2055 Albert Street
PO Box 1949
Regina, SK S4P 0E3

This booklet outlines the plan benefits, but it is not a substitute for the policy. The benefits outlined herein are subject to the terms, limitations, and exclusions as provided in the policy issued to *Saskatchewan Retirees Association.* This booklet will not be amended each time policy provisions change, so contact *Saskatchewan Retirees Association* if you have questions regarding this coverage.

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