



SASKATCHEWAN RETIREES ASSOCIATION

MASTER GROUP BENEFITS POLICY

Group Name: Saskatchewan Retiree
Association

Group Policy # 282368

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Underwritten By Group Medical Services | 2055 Albert Street, Po Box 1949 Regina, SK S4P 0E3

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Definitions

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

General Conditions

This policy shall not be assignable by either party without the prior written consent of the other party. Any application, notice, report, proof, request or communication to be made, given to or filed with GMS must be in writing and must be so made and delivered to or sent by registered mail or filed with GMS at its office.

This policy shall be governed by the laws of the Province of Saskatchewan. Should any provision of this policy be held by a court to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force.

This policy supersedes any previously issued policy(ies). Where this policy is issued in conjunction with, or supplemental to, an existing policy, and where provisions of this policy and the previous policy conflict, the provisions of this policy shall apply.

Making Changes to the Members Plan

Members can request changes to their Dental options, Drug options, through the My GMS portal or by submitting a written request via letter or email to GMS. This must be done within 31 days of the effective or renewal date, and only if no claims have been made. Approved changes will apply for the rest of the policy year. Reimbursement for claims on additional benefits purchased may be prorated for the remaining term of the policy year. Note: orthodontic coverage is only available with Dental - \$2,000 and has a two-year waiting period.

1) Premiums

- 1.1 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 Member's family status (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 of life event change such as marriage, death, divorce, the addition or removal of a Dependant, family status can be downgraded or upgraded during the policy year. The change to coverage and any required adjustment to premiums will be effective the first of the month following receipt of the Member's request. The premiums for the change in coverage will remain in effect for the remainder of the entire policy year.
- 1.2 At the end of the period during which the premium rates are guaranteed against change by GMS in this policy, or at any time if no such guarantee is stated, GMS may change the premium rates of this policy provided that the Policy Holder receives at least thirty (30) days written notice. If any terms or conditions of this policy are amended, GMS has the ability to change the premium rate then in effect.

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

2) Payment Grace Period

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

3) Currency

3.1 All amounts payable under this policy shall be payable in Canadian dollars.

4) Termination of Policy

- 4.1 The Policy Holder may terminate this policy at anytime, by giving written notice to GMS at least thirty (30) days in advance. Termination shall take effect on the later of the date of termination stated in the written notice, or the date the written notice is received by GMS.
- 4.2 GMS may, by written notice to the Policy Holder at least thirty (30) days in advance, terminate this policy. If termination of the policy is due to the death of the subscribing Member, Extended Health Care and/or Dental Care benefits will continue without payment of premiums for the Dependants for the balance of the Policy Year.
- 4.3 A Member may terminate their coverage at any time, by giving written notice to GMS at least sixty (60) days in advance. Termination shall take effect on the later of the date of termination stated in the written notice, or sixty (60) days after the written notice is received by GMS.

5) Right to Amend

- 5.1 GMS reserves the right to amend any benefit provisions, terms and conditions. No other person has the authority to change this policy or to waive any of its provisions.
- 5.2 In order for a group to be eligible for benefits, the plan must retain a minimum participation level. Should the plan not consist of the preset minimum participation level for the year in question, GMS reserves the right to terminate or amend any benefit provisions, terms and conditions, including plan design and/or pricing.

6) Date Incurred

- 6.1 Expenses are deemed to have been incurred on the date the service was rendered or the supply was delivered. In the case of dental services that require multiple visits, the incurred date will be the date of the last visit or the date a final appliance has been placed.
Expenses incurred prior to the effective date of this policy are not eligible for coverage.

7) Right to Recover

- 7.1 GMS shall be entitled to a refund of the amount of any benefits paid under this policy in respect of services and supplies not paid for by the Member or Dependand, or for which the Member or Dependand was reimbursed otherwise than under this policy.
- 7.2 Whenever payments have been made by GMS in excess of the maximum amount of benefit necessary to satisfy the policy, GMS shall have the right to recover such excess payments from the persons covered by the policy, the Policy Holder or any other insurance companies, underwriters or administrators of similar benefit plans.

8) Default

- 8.1 Should the Policy Holder fail to fulfil any of the obligations stated herein ("event of default"), the Policy Holder shall have thirty (30) days from the date that GMS provides written notice to the Policy Holder of the default to remedy the default. Failure by the Policy Holder to remedy the default within the specified time shall, at GMS' option, and without prejudice to any other remedy available to GMS, render the policy terminated immediately. Termination of the policy will not in any way restrict GMS' ability to recover or commence action to enforce the terms of the policy.
- 8.2 Non-payment of premiums on or before their respective due dates, shall be considered an event of default. However, due to the regular and recurring nature of the payment of premiums, GMS shall not be required to provide the Policy Holder with written notice of this default. All terms of the policy shall have full force and effect as if written notice had been provided.

9) Action

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

10) Duplicate Coverage with Other Plans

10.1 After the benefits of the Government Plans have been determined, the excess benefits of this policy will be coordinated with those of other contracts or policies if the person is covered for similar benefits simultaneously under any other contract or policy.

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

- a) the group plan where the insured person is covered;
 - i. if a person is a Member of two plans, priority goes to:
 - ii. the group plan where the Member is an active full-time Employee;
 - iii. the group plan where the Member is an active part-time Employee;
 - iv. the group plan where the Member is a retiree;
- b) the group plan where the person is covered as a Dependant spouse;
- c) the private plan (Individual Health Plan) where the insured person is covered.

Dependant Children

- d) the group plan of the parent with the earlier birthdate (month/day) in the calendar year;
- e) the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate;
- f) 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.
- g) the private plan (Individual Health Plan) where the insured person is covered.

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

11) Furnishing of Information: Access to Records

11.1 The Policy Holder shall promptly forward to GMS:

- a) all information and particulars necessary to establish the eligibility and interest of any Member;
- b) applications, if any, by Members for coverage; and
- c) all information and particulars of, or relating to, any change in the coverage of an Member, or termination of the coverage of an Member.

11.2 Clerical errors on the part of the Policy Holder shall not prejudice the coverage of any Member.

11.3 GMS may without the consent of any person, release to or obtain from any other company or administrator of benefit plans, any information with respect to any person which GMS requires to administer claims or co-ordinate benefits under this policy and any person claiming benefits under this policy shall furnish such required information.

11.4 The Policy Holder shall from time to time whenever requested by GMS during the continuance of this policy and within one (1) year after its final expiration, permit GMS to inspect such records of the Policy Holder as

may be necessary to verify said information and particulars.

12) Members Eligible for Coverage

12.1 In order to be eligible for coverage under this policy you must be a Member of the SRA, and must apply within sixty (60) days of the latest of the following dates:

- a) 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 as a surviving spouse of an employee; or
- b) the date of cancellation for 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.

12.2 SRA Members currently enrolled under an extended health and dental benefit plan with comparable benefits to this policy are not required to provide medical evidence to GMS if applying for coverage prior to the earlier of the following dates:

- a) twenty-four (24) months of retiring from active work; or
- b) reaching age seventy (70).

If applying after the earlier 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.

12.3 Eligibility is contingent upon full payment of all required premiums.

12.4 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.

12.5 Members must purchase a health plan in order to be eligible to purchase a dental plan.

13) Effective Date of Coverage for Members

13.1 Coverage for an eligible Member becomes effective on the date they become eligible. The renewal date is July 1st of each year. The coverage effective date will be the first day of month in which the Member becomes eligible or approved by GMS.

14) Termination and Suspension of a Member's Coverage

14.1 The coverage of a Member under this policy terminates automatically on the earliest of the following dates:

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

14.2 If a Member quits the Health plan, they may rejoin, subject to approval or denial through medical underwriting. If a Member quits the Dental plan, they cannot rejoin.

14.3 Members can suspend coverage under this policy if returning to active employment with an eligible SRA Member employer and have not previously suspended coverage.

14.4 To reinstate coverage under this policy, Members must reapply:

- a) under the same level of coverage in effect when the Member suspended coverage;
- b) within two (2) years of the suspension; and
- c) within sixty (60) days of losing coverage under the employer's group benefit plan. Members who do not reapply with sixty (60) days of losing coverage will be subject to medical underwriting.

14.5 Members who reinstate coverage under this policy within the same policy year of

suspending coverage, will have benefit usage retained and applied against annual maximums until the new policy year.

15) Dependant's Eligible for Coverage

15.1 A Member's Dependant shall be eligible for coverage on the latest of the following dates:

- a) the date that the Member becomes eligible for coverage under this policy; or
- b) the date that the individual(s) becomes a Dependant as defined in this policy.

15.2 Notice of Dependant eligibility shall be provided in writing to GMS.

16) Effective Date of Coverage for Dependents

16.1 The coverage of an eligible Dependant of an eligible Member becomes effective on the latest of the following dates:

- a) on the date the Member's coverage becomes effective.
- b) on the date the Dependant first meets the eligibility requirements; or
- c) the first of the month following eligibility.

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

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

16.4 No Dependant of a Member shall become covered under the health plan if the Member is not simultaneously covered under the health plan. No Dependant of a Member shall become covered under the dental plan if the Member is not simultaneously covered under the dental plan.

17) Termination of Dependant's Coverage

17.1 This coverage of a Dependant under this policy terminates automatically on the earliest of the following dates:

- a) the date of termination of the coverage of the Member of which the person is Dependent.
- b) the date that the person ceases to satisfy the definition of a "Dependant" or "eligible Dependant";
or
- c) the end of the period for which required premiums for Dependant coverage, on behalf of the Member, have been paid.

17.2 In the event of death of the Member, Group Medical Services will continue the Extended Health Care and/or Dental Care benefits without payment of premium for the Dependents (as defined in this policy) until the earliest of:

- a) The date the Dependant is no longer deemed a Dependant (as defined in this policy);
- b) The date similar coverage is obtained elsewhere;
- c) The date which is to the balance of the Policy Year; or
- d) The date which the group policy terminates.

18) Payment of Claims

18.1 GMS may pay benefits under this policy to the Member who incurred the expense for themselves or their covered Dependents, or in some situations GMS may pay part or all of the benefit directly to the provider of the service.

18.2 In order for GMS to pay health benefits, submit original receipts attached or the original receipts with the following information: GMS policy number, patient name, address and phone number, date and details of service and Physician referrals where required.

18.3 In order for GMS to pay dental benefits, submit either a Group Medical Services' dental claim form or a standard dental claim form. GMS will supply the Dentist or the patient with claim forms, either in advance or upon request.

18.4 Members can submit claims through their [My GMS account](#) or via mail to the address below. Once

submitted to My GMS, Members can track claim payments, sign up for direct deposit, and get more information about a claim through their Explanation of Benefits.

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

19) Notice of Claim

19.1 Claims must be submitted to GMS within twelve (12) months of the date of service, in order to be eligible for reimbursement. However, if this policy terminates, Members must submit any claim to GMS within thirty (30) days following the date of termination of this policy.

Schedule of Benefits - Extended Healthcare Plan

This document outlines the terms and conditions of the Group Health benefits; all of the terms and conditions of the General Group Policy conditions also apply. Please refer to that policy for the respective terms and conditions.

1) Health Benefits

IN CANADA HEALTH BENEFITS ARE PAYABLE TO A COMBINED MAXIMUM OF \$10,000 PER PERSON PER POLICY YEAR.		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.	
1.1	IN CANADA HEALTH BENEFITS *Please note some benefit provisions may be limited to within the Member's province of residence. **Please note, Vision and Hearing Aid benefits are currently the only two benefits listed below that will be considered for reimbursement if purchased online or out-of-Canada.	PERCENT ELIGIBLE	MAXIMUM
1.2	**Vision Care: <u>Eye Exams</u> Provides payment for an eye exam, by a qualified physician, optometrist, or ophthalmologist, to measure the visual acuity of the patient. <u>Lens/Frames/Contacts</u> (if applicable is in force prior to the date of this amendment) Provides payment for prescription lenses, frames, contact lenses, and/or refractive laser eye surgery.	80%	Eye exams - \$125 Limit of one eye exam, per person per Policy Year Eyeglasses/prescription sunglasses/contact lenses - \$400 per person per two (2) Policy Years

<p>1.3 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.</p> <p>50% of the cost of the 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.</p>	100%	Unlimited reimbursement
<p>1.4 Semi-Private Hospital Room: Payment on a pay-patient basis for semi-private Hospital room charges. This benefit excludes stays for convalescent and respite care.</p>	100%	Unlimited reimbursement
<p>1.5 Private Duty Nursing: Payment of private duty nursing charges in- Hospital or in-home as palliative care, when ordered in writing by a Physician. Nursing services in the home must commence immediately following release from Hospital and must be consistent with the Treatment of the condition for which the patient was hospitalized. All services must be rendered by a Registered Nurse or Licensed Practical Nurse, who is not Immediately Related to the patient or who does not ordinarily reside in the patient's home. Nursing services rendered in licensed institutional type facilities are excluded from this benefit.</p>	80%	\$5,000 per person per Policy Year
<p>1.6 Prescription Drugs: Payment for the charges of Formulary and Non-Formulary drugs not covered by the Member's provincial health prescription drug services formulary plan, when ordered in writing by a Physician. Generic substitutions may be used to replace brand name prescription drugs, unless "no substitutions" is specifically indicated on the prescription by the Physician.</p> <p>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.</p>	100%	<p><u>Prescription Drugs</u> \$1,700 per person per Policy Year Deductible – equivalent to the pharmacy dispensing fee</p> <hr/> <p><u>Prescription Drugs</u> \$2,500 per person per Policy Year Deductible – equivalent to the pharmacy dispensing fee</p>

<p>All claims for prescription drugs, whether by pay-direct drug card or by manual submission, must first be submitted to the Member's 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. Group Medical Services coverage applies after the benefits of the Government Plans, including but not necessarily limited to the provincial drug plan, have been determined.</p>		<p><u>Prescription Drugs</u></p> <p>\$3,500 per person per Policy Year</p> <p>Deductible – equivalent to the pharmacy dispensing fee</p>
<p>1.7 Accidental Injury to Natural Teeth:</p> <p>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 and coverage must be continuous for this benefit to be maintained. Reimbursement of services is subject to fees provided in their province of residence's Dental Fee Schedule in effect at the time that the services are rendered. This benefit excludes dental implants.</p>	<p>100%</p>	<p>\$2,000 per person per Policy Year</p>

<p>1.8 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.</p>	80%	<p>\$400 per specialty per person per Policy Year</p> <p>\$2,000 annual combined maximum</p> <p>(chiropractic, podiatry, acupuncture, speech therapy, massage therapy, physiotherapy, reflexology, osteopath and naturopathy treatments)</p>
<p>1.9 Mental Health Practitioners: Provides payment for the stated services under the schedule of benefits. All services must be provided by a mental health practitioner who is licensed, certified, or registered by their provincial regulatory agency, or a registered member of a professional association recognized by GMS.</p>	80%	<p>\$400 combined maximum, per person per Policy year</p> <p>(clinical psychology, clinical counsellors, social workers, psychotherapists)</p>
<p>1.10 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.</p>	80%	<p>Breast Prosthesis - Unlimited</p> <p>Surgical bras - two (2) per person per Policy Year</p>
<p>1.11 Wheelchairs, Motorized Scooters and Hospital Beds: Provides payment for the purchase or rental of wheelchairs, geriatric chairs, motorized scooters, and/or hospital beds when medically necessary. This benefit does not cover hospital beds for individuals confined to, or resident in an active hospital, convalescent facility, nursing home, extended care facility, rehabilitation center, rest home or personal care home. Must submit an estimation for review before purchase.</p>	80%	<p>\$500 per policy per five (5) Policy Years</p>
<p>1.12 Casts and Crutches: Payment of the charges for fiberglass casts and for the purchase or rental of crutches.</p>	80%	Unlimited reimbursement
<p>1.13 Patient Walkers: Payment for the rental of, or at the option of GMS, the purchase of patient walkers, when ordered in writing by a Physician.</p>	80%	<p>\$300 per person per three (3) Policy Years</p>
<p>1.14 Artificial Eyes, Limbs and Larynx: Payment of the charges for artificial eyes, limbs or larynx.</p>	80%	Unlimited reimbursement
<p>1.15 Diabetic Supplies and Equipment: Payment for the purchase of diabetic supplies, including insulin infusion sets, testing devices and flash glucose and continuous glucose monitors when ordered in writing by a Physician for use in the home. This benefit excludes insulin pumps, insulin, and other medications</p>	100%	<p>Diabetic Supplies – unlimited reimbursement</p> <p>Flash & Continuous Glucose Monitors (including sensors) - \$2,500 combined per policy year</p> <p>Capillary Blood Glucose Testing Devices – one (1) per person per five (5)</p>

		policy years to a benefit maximum of \$500.
<p>1.16 Ostomy Supplies: Payment for the purchase of ostomy supplies when required for use in the home.</p>	80%	Unlimited reimbursement
<p>1.17 Oxygen Equipment, CPAP Machine and Supplies : 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 and machine when prescribed by a physician for personal use in the home. This benefit includes payment for the cost of oxygen</p>	80%	<p>\$500 per person per Policy Year for the purchase of supplies</p> <p>\$275 per person per Policy Year for the purchase of CPAP machines</p>
<p>1.18 Custom Made Foot Orthotics: Payment for the purchase of custom made foot orthotics when made by an accredited podiatric biomechanics laboratory. The orthotic must be created by using 3- dimensional impressing techniques include foam box impression, plaster casting and direct mold. This benefit excludes payment for the costs of assessment, casting and/or scanning.</p>	80%	Once per person per three (3) Policy Years to a maximum of \$400
<p>1.19 Orthopedic 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 shoes 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 any modifications done and confirmation that the therapeutic footwear is customized for the specific foot condition as diagnosed. This benefit excludes payment for sandals, runners, and boots/shoes with trends or fashion that have pointed toes.</p>	80%	\$200 per person per Policy Year
<p>1.20 **Hearing Aids: Payment for repair of, or for purchase of a new, hearing aid when prescribed by and/or fitted by an audiologist or as legislated in the insured person's province of residence. This benefit includes hearing aids purchased online or out of Canada</p>	80%	\$1,200 per person per three (3) Policy Years
<p>1.21 Blood Pressure Monitors: Payment for the purchase of a blood pressure monitor when ordered in writing by a Physician for use in the home.</p>	80%	One per family per five (5) Policy Years

<p>1.22 Cardiac Rehabilitation:</p> <p>payment for the 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.</p>	80%	\$225 per person per Policy Year
<p>1.23 *Out-of-Province Referral:</p> <p>Charges for Physician, anaesthetic, radiology, laboratory, Hospital and ambulance services outside of the province, for Treatment, which is not available in their province of residence, when recommended by a specialist. The claim must have prior written approval from GMS. Payment will not be made 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.</p>	80%	Lifetime maximum of \$50,000 per person
<p>1.24 Other Health Benefits:</p> <p>Payment for the purchase or rental of splints, wigs, braces with metal components, trusses, rib belts, air casts, clavicle straps, cervical collars, shoulder immobilizers, sacroiliac corsets, compression stockings, aero chambers and compressors. A Physician must prescribe any of the above items.</p>	80%	<p>\$500 per person per Policy Year with the following exception:</p> <p>Compression stockings – four (4) pair per person per Policy Year</p>
<p>1.25 GMS Care Network:</p> <p>Provides Members and Dependents with wellness services to help improve mental, physical, financial and social wellbeing. Members and Dependents have access to the following:</p> <p>Assistance Program Accessible and personalized care across the health spectrum for 5 hours of counselling for Members 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 a Members convenience.</p> <p>Telemedicine Access instant virtual telemedicine service with a network of Doctors. This benefit will allow Members and Dependents to connect with general practitioners 24/7/365, communicate via text message, audio or video chat, manage and store medical records, receive medical advice, prescriptions.</p> <p>Internet-Based Cognitive Behavioural 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</p>	100%	<p>Each person covered under the policy gets up to 25 hours of counselling and coaching. This includes five hours of individual counselling, five hours of couples counseling, and five hours for three different types of coaching: health, life or transition, and career. Plus, unlimited 30-minute legal and financial consultations.</p>

reduce life-disrupting symptoms without waiting.

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

2) Health Benefits Conditions and Exclusions

The following conditions and exclusions apply to the Health Benefits:

2.1 Health benefits are available within Canada.

2.2 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.

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

2.4 The following services or supplies are excluded from coverage:

2.4.1 Expenses compensable under Worker's Compensation Laws or any Government Agency;

2.4.2 Expenses for cosmetic purposes;

2.4.3 Expenses for diagnostic or investigative testing;

2.4.4 Expenses from services provided by family members;

2.4.5 Expenses for examinations related to surgical procedures;

2.4.6 Expenses post-surgical lenses;

2.4.7 Expenses relating to non-prescription eyeglasses or non-prescription sunglasses;

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

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

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

2.7 No benefit will be provided that is a duplication of any service, allowance or reimbursement supplied by an existing government or private plan, all benefits payable under this policy will be coordinated so that the total payment from all coverage's shall not exceed the amount for which the claim is made.

2.8 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; 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.

2.9 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.

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

3) Travel Benefits

When eligible expenses are incurred outside of their province of residence or Canada due to Treatment of sudden or unexpected illness or Accidental bodily injury, 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.		For the expenses to be eligible, the sudden or unexpected illness or Accidental injury, and the necessary diagnosis and Treatment must occur within the first 60 days after leaving Canada or within the first 180 days after leaving their province of residence if the person remains in Canada.
3.1 Out of Province/Canada Health Benefits	PERCENT ELIGIBLE	MAXIMUM
	100%	The maximum amount payable is \$5,000,000 Per person per lifetime
3.2 Hospitalization: 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.		
3.3 Physicians and Surgeons: Charges for Emergency services of a Physician or surgeon for diagnosis and Treatment of an acute illness or injury.		
3.4 Health Practitioners: Charges for the Emergency services of a chiropractor, chiropodist/podiatrist, osteopath, and/or physiotherapist.		\$300 per person per Policy Year
3.5 Private Duty Nursing: Expenses for the professional services of a Registered Nurse for private duty nursing while hospitalized during an acute Emergency illness or injury. The services must be provided by someone who is not Immediately Related to the patient or who does not ordinarily reside in the patient's home.		

<p>3.6 Emergency Transport:</p> <p>Charges for the use of a licensed professional road ambulance in an Emergency that requires immediate transportation of the Member or Dependant to the nearest Hospital where adequate facilities are available. The use of an air ambulance or regular scheduled airline to transport the insured person back to Canada for further in-Hospital Treatment, upon written recommendation of the attending Physician, and the prior approval of GMS. (Transportation within Canada is not included.)</p>		
<p>3.7 In-flight Medical Attendant:</p> <p>GMS will reimburse the cost of one return trip economy fare for a medical attendant should a regular scheduled airline be attend, rather than an air ambulance, for the return of a patient to Saskatchewan, when a Physician recommends that a medical attendant accompany the patient. The person attending must not be a friend, relative, associate or other person who was travelling with the patient when the Emergency occurred.</p>		
<p>3.8 Accidental Injury To Natural Teeth:</p> <p>Expenses for the repair or replacement of natural teeth or permanently attached artificial teeth necessitated by an Accidental blow to the mouth, provided that dental Treatment occurs within ninety (90) days of the accident and prior to returning to their province of residence. This benefit excludes dental implants.</p>		\$1,000 per person per Policy Year
<p>3.9 Prescription Drugs:</p> <p>In Emergency situations, drugs and medication obtained on the prescription of the attending Physician and supplied by a licensed pharmacist. Refills of prescriptions, and any associated Physician's fees, are excluded from coverage.</p>		\$300 per person per Policy Year
<p>3.10 Return of Remains:</p> <p>Charges for the homeward carriage of a deceased Member or covered Dependant.</p>		
<p>3.11 Vehicle Return:</p> <p>The costs, with GMS approval, for returning a Member's vehicle, either private or rented, to his/her residence or nearest appropriate vehicle rental agency, when the Member and any travel companions are unable to do so due to unexpected illness or Accidental injury. This benefit is only available when GMS returns the Member to their Province of Residence for further in-Hospital medical treatment. Eligible costs include the return of a vehicle performed by a professional agency or the following necessary and reasonable expenses incurred by an individual returning the vehicle on their behalf: fuel, meals, overnight accommodation, one-way economy airfare. Expenses incurred by anyone travelling with the person returning the vehicle are not covered. Written medical certification and original paid receipts for the costs incurred are required.</p>		\$1,000 per trip

<p>3.12 24-Hour Travel Assistance Services:</p> <p>Twenty-four (24) hour service anywhere in the world is provided to assist the Member to obtain medical Treatment, co-ordinate medical care and transportation, verify coverage and provide support in areas of foreign languages. The Member, or someone on their behalf, must contact our designated travel assistance firm prior to Treatment whenever possible.</p>		
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4) Travel Benefits Conditions and Exclusions

In addition to the Health Conditions and Exclusions listed below, the following exclusions and limitations apply to travel outside your Province of Residence and outside Canada.

4.1 Coverage for Pre-Existing Medical Conditions

This policy does not cover any expenses related directly or indirectly to the following:

For Members Under 75 Years of Age:

- a) Any medical condition, related condition, or symptoms (whether diagnosed or not) that have not been stable at any time in the 90 days before your departure date.
- b) Any heart or lung condition that has not been stable at any time in the 90 days before your departure date.

For Members 75 Years of Age and Older:

- a) Any medical condition, related condition, or symptoms (whether diagnosed or not) that have not been stable at any time in the 180 days before your departure date.
- b) Any heart or lung condition that has not been stable at any time in the 180 days before your departure date.

4.2 The Member or someone on their behalf must contact our designated travel assistance firm prior to Treatment whenever possible. Failure to contact our designated travel assistance firm within twenty-four (24) hours of receiving Treatment or admission to Hospital will limit benefits, otherwise payable to the Member, to 70% of eligible charges to a maximum of \$50,000.

4.3 Maximums are payable per person per Policy Year, unless otherwise stated. All amounts stated are in Canadian dollars.

4.4 It is the responsibility of the Member to provide proof that the dates of travel are consistent with the terms of this policy.

4.5 No benefit will be provided for expenses incurred where the patient acts against medical advice or the advice of GMS.

4.6 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.

4.7 No benefit will be provided for Treatment at a diagnostic facility unless pre-approved by GMS.

4.8 No benefit will be provided for emergency air transportation to return the Member to their Province of Residence, which is not arranged and pre-approved by GMS.

4.9 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.

- 4.10 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.
- 4.11 No benefit will be provided for any services or expenses incurred when a journey is undertaken for the purpose of obtaining medical or surgical diagnosis or Treatment, or when any medical Treatment is pre-scheduled prior to departure from their province of residence.
- 4.12 No benefit will be provided for expenses resulting when travel is booked or commenced contrary to medical advice.
- 4.13 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.
- 4.14 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.
- 4.15 No benefit will be provided for coronary artery angioplasty, cardiac surgery or implantable cardiac defibrillator (ICD) (including any associated diagnostic tests or charges), unless necessary in a medical Emergency and approved by GMS prior to any actions.
- 4.16 GMS does not cover expenses arising where:

- a) Before a Member's departure date, an official travel advisory is issued by the Canadian government, stating "Avoid non-essential travel" or "Avoid all travel" for the country, region, city or other destination, (including cruise ship) that are part of your travel arrangements.

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

- 4.17 No benefit will be provided for expenses resulting from the regular care of a chronic condition.
- 4.18 No benefit will be provided for expenses incurred as a result of non-adherence with medical treatment prior to departure.
- 4.19 No benefit will be provided for transplants, including but not limited to organ transplants, bone marrow or stem cell transplants.
- 4.20 GMS is not responsible for the availability, quality or results of any medical treatment or transportation or failure to obtain medical treatment.
- 4.21 No benefit will be provided for any endovascular surgical procedures, either done individually or in combination with conventional surgical procedures.
- 4.22 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.
- 4.23 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 their Province of Residence.
- 4.24 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.
- 4.25 If eligible expenses are incurred due to the fault of a third party, GMS may take legal action against the faulty party in their name. This requires their full cooperation in providing GMS any necessary information.
- 4.26 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.

- 4.27 GMS is authorized to receive reports indicating diagnosis and services rendered to covered persons from any Physician, health care provider, other person, Hospital or institution.
- 4.28 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.
- 4.29 When travelling outside of Canada, Members 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. However, all travel benefit conditions and exclusions are applicable to each subsequent trip, including out-of-province/Canada benefit conditions and exclusion 4.1, regardless of the Member's point of departure from Canada.

5) Optional Add-On Travel Days

The Optional Add-On Travel Days ("Option") extends the maximum trip duration of the included Travel Benefit, which provides sixty (60) days of coverage per trip, by the number of additional days purchased. Optional Add-On Travel Days may be purchased in increments of fifteen (15), thirty (30), or ninety (90) days per trip.

All terms and conditions including benefits, maximums, and limitations provided under the included Travel benefit apply equally to the Optional Add-On Travel Days, unless otherwise stated below.

Eligibility

To be eligible for the Optional Add-On Travel Days, the Member, and any/all covered Dependents where applicable, must have enrolled for health benefits, complete the medical questionnaire and be approved as determined by GMS.

Dependants as defined under this Policy may be covered if included under the Member's coverage classification (Single/Couple/Family).

Enrollment and Purchase Rules

Partial participation in the Optional Add-On Travel Days is not permitted. If one covered person under the Policy is ineligible or does not purchase the Option, the Option will not be available to any insured person under that Policy. Premium must be paid in full at the time of purchase. Coverage under this Option must be purchased annually at renewal. It does not automatically renew and does not carry forward to subsequent Policy Years.

Members and any/all covered Dependents who elect the Optional Add-On Travel Days must complete the medical questionnaire at each yearly renewal.

A Member who elects the Optional Add-On Travel Days may revoke their selection within thirty (30) days of the date of election. The Member must notify GMS within this thirty (30) day period in order to receive a refund of premium, provided no claims have been incurred. Once the thirty (30) day period has passed, the Option remains in force for the remainder of the Policy Year and is non-refundable.

Effective Date and Termination

Per Trip:

Effective Date: The Optional Add-On Travel Days take effect after the first sixty (60) days of the included Travel benefit have been used.

Termination Date: The Optional Add-On Travel Days terminates on the earlier of:

- (a) the Member's return to the Province of Residence,

(b) the end of the combined included Travel Benefit and Optional Add-On Travel Days period.

Misrepresentation

Any material misrepresentation, provision of incorrect information, or non-disclosure of information at the time of application will result in non-payment of any claim and will void the Optional Add-On Travel Days coverage. A premium refund will be provided for non-eligible coverage.

Pre-Existing Conditions and Stability Requirements

Coverage for pre-existing medical conditions is subject to the same stability periods as outlined under the included Travel Benefit.

Maximum and Aggregations

Total maximum trip length equals the included Travel Benefit (60 days) plus the Optional Add-On Travel Days (15, 30, or 90 days, as purchased).

Overall maximum coverage is \$5,000,000 per person per lifetime for all Emergency Out-of-Province/Canada expenses combined under the included Travel Benefit and any purchased Optional Add-On Travel Days.

Rates and Premium Payment

Rates are established on a Single, Couple, or Family basis for each Optional Add-On Travel Days offering.

Premium must be paid in full at the time of purchase. No portion is refundable after the effective date of coverage, except as provided under the thirty (30) day revocation provision above.

6) Dental Benefits

6.1 This document outlines the terms and conditions of the Group Dental benefits; all of the terms and conditions of the General Group Policy conditions also apply. Please refer to that policy for the respective terms and conditions.

7) General Provisions

- 7.1 Services totaling \$600 or more must have prior approval from GMS before the services are begun.
- 7.2 The eligible services listed below are not an attempt to dictate dental health requirements. The dentist is best able to determine the dental treatment program for the Member, although those services may not be eligible under this plan.
- 7.3 If the Member or Dependents incur dental Treatment while outside their Province of Residence, the plan will reimburse on the same basis as though the expenses were incurred in the province of Saskatchewan.

8) Preventative Dental Services

In Canada Dental Benefits	PERCENT ELIGIBLE	Maximum
Preventative Dental Services: Subject to the limitations and exclusions	80%	<u>Dental - \$1,200</u> Combined \$1,200 for all Preventative, Basic, and Major Dental Services

stated elsewhere herein, "Preventative Dental Services" means:		<u>Dental - \$2,000</u> Combined \$2,000 for all Preventative, Basic, and Major Dental Services
8.1 Preventative dental services including: a) scaling, b) polishing, c) application of sodium or topical fluoride Treatment.		Based on units of 15 minutes: a) Ten (10) units per person per Policy Year combined with root planing, b) Two (2) units per person per Policy Year, c) Two (2) units per person per Policy Year.
8.2 Pit and fissure sealants.		One (1) per tooth per lifetime for individuals under the age of eighteen (18) years.
8.3 Protective mouth guard appliances.		One (1) per Policy Year for Dependants under sixteen (16) years of age, and one (1) per three (3) Policy Years for Dependants sixteen (16) years of age and over.
8.4 Space maintainers to maintain, but not obtain, space		
8.5 Occlusal adjustment and equilibration.		Four (4) units per person per Policy Year
8.6 Interproximal diskings of teeth.		
8.7 Bruxism appliances used for the control of oral habits		One (1) per Policy Year for Dependants under sixteen (16) years of age, and one (1) per three (3) Policy Years for Dependants sixteen (16) years of age and over.

9) Basic Dental Services

Basic Dental Services: Subject to the limitations and exclusions stated elsewhere herein, "Basic Dental Services" means:	80%	<u>Dental - \$1,200</u> Combined \$1,200 for all Preventative, Basic, and Major Dental Services
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		Dental - \$2,000 Combined \$2,000 for all Preventative, Basic, and Major Dental Services
9.1 Complete dental examination, which would include history, medical and dental; clinical examination and diagnosis.		Once per person per three (3) Policy Years
9.2 Limited oral examination: a) recall and specific examinations, b) Emergency examinations.		(a) Twice per person per Policy Year subject to a combined maximum of two (2) examinations per Policy Year, (b) Unlimited.
9.3 Dental x-rays (radiographs): a) a complete (full mouth) or panoramic series, b) Intra-oral and Extra-oral		(a) One of either type per person per three (3) Policy Years, (b) Ten (10) films per person per two (2) Policy Years.
9.4 Treatment planning and consultations.		
9.5 Basic oral surgery including erupted teeth extractions, surgical extractions, surgical excisions, surgical incisions, and post surgical care.		
9.6 Basic restorations of teeth including caries, trauma and pain control, amalgam restorations, prefabricated restorations and plastic restorations.		
9.7 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 one (1) per tooth per five (5) Policy Years
9.8 Diagnostic casts.		Once per person per three (3) Policy Years
9.9 Anaesthesia.		
9.10 Surgical periodontal services including gingival curettage, gingivoplasty, gingivectomy, and flap approach.		Each type of surgery is limited to one (1) per site (sextant) per person per Policy Year
9.11 Non-surgical periodontal services including management of oral disease and desensitization.		

9.12 Periodontal root planing.		Ten (10) units per person per Policy Year combined with scaling
9.13 Denture relining and rebasing.		Once per person per three (3) Policy Years per arch
9.14 Removable prosthodontic services including denture repairs and additions, tissue conditioning for dentures and miscellaneous denture services (resilient liner and resetting of teeth).		
9.15 Fixed prosthodontic repairs including replacement repairs, removal of existing fixed bridge/prosthesis, reinsertion, recementation, and fixed bridge/prosthesis repairs.		

10) Major Dental Services

<p>MAJOR DENTAL SERVICES:</p> <p>Subject to the limitations and exclusions stated elsewhere herein, "Major Dental Services" means:</p>	65 %	<p><u>Dental - \$1,200</u> Combined \$1,200 for all Preventative, Basic, and Major Dental Services</p> <p><u>Dental - \$2,000</u> Combined \$2,000 for all Preventative, Basic, and Major Dental Services</p>
<p>10.1 Full and/or partial upper and lower dentures, including any necessary adjustments.</p>		<p>Initial complete or partial dentures and bridges are limited to teeth extracted while covered under this plan, to a maximum of one (1) per arch.</p> <p>Replacement complete or partial dentures and 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.</p> <p>The cost of transitional dental work will be deducted from the final bridge or denture, if done within one (1) year.</p>

<p>10.2 Dentures – Removable Prosthodontics</p>		<p>Initial complete or partial dentures when at least one tooth being replaced was extracted while you are covered under this plan</p> <p>Replacement or complete partial dentures when additional teeth are extracted while you are covered under this plan, or if the existing appliance is at least five (5): years old</p> <p>Denture adjustments once per policy year</p> <p>Denture repairs</p> <p>Tissue conditioning</p> <p>Miscellaneous denture services</p>
<p>10.3 Bridges – Fixed Prosthodontics</p>		<p>Initial bridge pontics and fixed bridge retainers when at least one tooth being replaced was extracted while you are covered under this policy.</p> <p>If there are three (3) or more teeth missing in the arch, GMS will pay up to the cost of a standard partial denture only</p> <p>Replacement bridge pontics and fixed bridge retainers once every five (5) policy years</p> <p>Bridge repairs</p> <p>Removal of existing bridge, reinsertion and re-cementation</p>
<p>10.4 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.</p>		<p>Replacements must be separated by at least five (5) years.</p>
<p>10.5 Denture adjustments.</p>		<p>Once per person per Policy Year</p>
<p>10.6 Orthodontics</p> <p>Payments including provision of services and appliances for the correction of malocclusion including diagnostic procedures, formal treatment, and retention.</p> <p>Eligible for Dependant children if under the age of 18 when treatment begins.</p> <p>An orthodontic treatment plan must be submitted to and approved by GMS prior to payment being eligible.</p>	<p>50%</p>	<p>Orthodontics are available in Dental - \$2,000 only.</p> <p>Orthodontic benefits have a 2 year waiting period.</p> <p>Orthodontic benefits have a lifetime maximum of \$2,500.</p>

Lump sum payments are not eligible. If the treatment plan is paid in full, reimbursement will be limited to the initial fee and the balance in equal monthly installments.		
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11) Dental Benefits Conditions and Exclusions

The following conditions and limitations apply to the Dental benefits:

- 11.1 This 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 this policy and shall be your responsibility. Where there is any dispute as to necessary and adequate dental services, the reasonable determination of GMS shall be final.
- 11.2 GMS will pay for services and procedures only to the maximum amounts as provided for in the Dental Fee Guide. Any charges over and above the Dental Fee Guide will be the Insured Person's responsibility.
- 11.3 Coverage must be continuous for Dental Care benefits to be maintained. Upon cancellation, all Dental Care benefits will cease, including any preapproved services or Treatments.
- 11.4 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 an 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.
- 11.5 GMS will cover standard cast chrome with external clasp retainer's only or acrylic partial denture and where a more complicated or precision appliance is supplied, the extra cost is the Insured Person's responsibility.
- 11.6 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.
- 11.7 Only dentists will be paid for x-rays.
- 11.8 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 person became covered by this policy.
- 11.9 If there were three (3) or more teeth missing prior to the Insured Person becoming eligible for coverage under this policy, then GMS will pay for a partial denture only.
- 11.10 Replacement of identical restorations will only be covered once every twelve (12) months.
- 11.11 Orthodontic services including record fees, start-up fees, monthly maintenance and retention devices will not be covered in dental – \$1,200 benefits
- 11.12 The following services or supplies are excluded from coverage from this 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:
 - i) Treatment performed for cosmetic purposes only,
 - ii) Congenital defects or developmental malformations or replacements of congenitally missing teeth, or

- iii) 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, stolen or broken dentures are not eligible unless they are 5 years or older.
- h) Replacement/repair of orthodontic braces in dental - \$1,200.
- i) Spare or duplicate prosthetic devices or appliances.
- j) Missed appointments.
- k) Completion of claim forms or pre-determinations.
- l) Instruction in dental hygiene.
- m) Nutritional counselling.
- n) Hypnosis.
- o) Prescribed drugs.
- p) Experimental procedures.
- q) Tissue grafts.

Definitions

In this policy, unless otherwise specifically provided;

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

Accidental - a happening due to external, sudden, fortuitous causes beyond the Member's or Dependent's control.

Add-On Travel Days - means the number of additional travel days purchased by an SRA Member under this Option for a single trip.

Anniversary Date - the annual recurrence of the original date of issue of this Policy.

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

Child - a Member's son or daughter, either natural or adopted, and includes the son or daughter of the Member's spouse, or a foster child, as defined by provincial legislation.

Couple Policy - a Policy covering a Member and one (1) eligible Dependent.

Dental Fee Schedule - 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 who do not have their own.

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

Dependent

- 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 maintained and publicly represented by the Member as the Member's spouse;
- b) any unmarried child of the Member or spouse (including step-child, adopted child or a child for whom the Member has been granted custody pursuant to an Order of the Court) who is chiefly dependent

upon the Member or spouse for support and maintenance:

- i. twenty (20) years of age and under; or
- ii. twenty-five (25) years of age and under, who is undergoing full-time student educational training; or
- iii. a developmentally or physically disabled child, regardless of age, if satisfactory proof of disability is received within thirty-one (31) days of the ages indicated above to ensure continuing eligibility. Satisfactory proof of disability must be provided on an annual basis.

Emergency - 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 - any alteration attached hereto or which is included with, or added subsequently to, the execution of the agreement between GMS and the Policy Holder.

Family Policy - a Policy covering a Member and more than one (1) eligible Dependent.

GMS - Group Medical Services and/or its representatives, affiliates or other service providers.

Government Plan - 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 - 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 - a spouse, mother, father, sister, brother, child, grandchild, mother-in-law, father-in-law, sister-in-law, brother-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.

Member Contribution - the amount, if any, which the Employer requires a Member to pay toward the premium for his/her benefit under this Policy.

Non-adherence - 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 - a Physician who specializes in the treatment of disorders of the eye.

Physician - 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 - the party referred to on the cover page of the Policy, being *Saskatchewan Retirees Association (SRA)*.

Policy Year - the twelve (12) months following the Anniversary Date of the Policy.

Province of Residence - the province that the 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 - charges that are comparable to those normally charged for that service in the particular area where the service is received.

Single Policy - a Policy covering a Member without Dependents.

Stable - 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 (*);

- 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 - a Physician who is licensed to practice surgery.

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 treatment directly referable to the condition, symptom or problem.

Trip - means travel by a Member and/or covered Dependents outside their Province of Residence for a continuous period of time not exceeding the maximum trip duration specified under the included Travel Benefit and any Add-On Travel Days purchased.

You or Your - any person who is eligible for coverage for any benefit under this Policy.