NORTHERN EMPLOYEE BENEFITS SERVICES
(NEBS)
Group 799
Plan Details
Your Group Benefits Plan

NORTHERN EMPLOYEE BENEFITS SERVICES (NEBS)
Group 799
Plan Details
Effective: June 1, 2017
Issued: June 8, 2017

For more information visit www.cooperators.ca and click on Group > Group Benefits
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INTRODUCTION

YOUR GROUP INSURANCE AND HEALTH BENEFITS PROGRAM

We are pleased to present to you a summary of each of the coverages provided by your employer. This booklet is designed to answer the most common questions regarding your group benefits program.

Please note:
All employers participating in the group benefits program have the following coverage:

- Basic Group Life Insurance
- Dependents Insurance
- Long Term Disability

Not all employers participating in the NEBS Group Benefits Program have the same optional coverage.

The optional plans available include:

- Short Term Disability
- Extended Health & Vision Care
- Dental Care
- Elected and Appointed Officials Insurance

For employers who choose coverage for elected councillors and appointed board members, the following coverages are available:

- Basic Group Life Insurance

Who is eligible?

All full-time employees under the age of 75 for Life and under the age of 65 for all other benefits who have completed the waiting period, are actively at work and who work a minimum of 20 hours per week, and elected councillors and appointed board members under the age of 75 for Life, if coverage is elected by the employer.

All Term Employees that fit the aforementioned criteria are eligible for the following benefits:
- term of 24 months or more, eligible for all benefits,
- term of less than 24 months but at least 12 months, eligible for all benefits except disability benefits,
- term of less than 12 months, not eligible for benefits.
Introduction

How do I apply?
By completing an enrolment form provided by your employer.

Do I have any choices?
Yes, there are several plans you can choose. You may choose to add additional levels of life insurance for yourself, your dependents, and/or your dependent parents.

If your employer participates in the extended health and vision care plan and/or the dental care plan, you can choose to participate or not. If you participate you have the choice of single coverage, spouse coverage or family coverage.

Are my dependents covered?
Yes, some benefit plans include family coverage provided your dependents meet the definition of a dependent contained in the benefit summary. Coverage for your dependents becomes effective the same date your coverage is effective.

Who is a dependent?

- Your spouse is a person of the same or opposite sex to whom you are legally married, or with whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse.
  
  - Benefits can be extended for a former spouse where you are required by court order to provide some or all of the benefits available under your plan. Note that you can only insure one person as your spouse for all benefits at any given time.

- Your dependent children are your or your spouse’s unmarried natural, adopted, or step children, or any other unmarried children for whom you or your spouse have been appointed legal guardian. Your dependent child is eligible for coverage if he/she:
  
  - is under age 21 and not working more than 30 hours a week, unless a full-time student,
  
  - is under age 25 and registered as a student at a college, university, trade school or similar educational facility and attending on a full-time basis, or
  
  - permanently incapacitated either prior to age 21 or while an eligible student (must be suffering from a permanent mental or physical infirmity and incapable of supporting himself/herself financially due to a medically diagnosed physical or psychiatric condition).

  ⇒ If your child is suffering from a medically diagnosed permanent mental or physical infirmity, or is a student, for continued coverage beyond age 21 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.

- Your spouse’s child is an eligible dependent if the child is also your natural or adopted child and your spouse is residing with you, insured under your plan and has custody of the child.

- A child for whom you or your spouse has been appointed guardian is not an eligible dependent unless NEBS 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 re-training program at an educational institution, excluding scholarships. If you have dependent children who are students over age 21, you must submit proof of student status annually (by completing the student declaration form).

• A parent (for the purpose of Optional Life Insurance only) under age 70 who is residing with you and who is financially dependent on you.

When do my employee benefits terminate?
Your benefits, under each coverage, terminate automatically at the age specified in each benefit explanation, retirement date or your retirement on pension. Other reasons for termination of coverage are termination of your service as an employee, termination of the master policy or plan text or cessation of premium and/or deposit payments.

Dependent survivor benefits for Extended Health and Dental
Your dependents’ coverage terminates when your coverage terminates, or when the dependent no longer is a dependent, except for extended health care and dental coverage which is extended for 1 year following the death of the employee.

Limitation of Action
Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or any other applicable legislation.

Where or when applicable legislation permits the use of a different limitation period, no action or proceeding at law or in equity shall be brought against Co-operators Life for payment of benefits under the policy or for any other related damages:

➢ prior to the expiration of 60 days after the claim form has been filed in accordance with the requirements of the master Policy; or

➢ unless brought:

   • where no benefits have been paid, within one year from the expiration of the time within which the claim form is first required by the Policy or from the date on which Co-operators Life first denies the claim for benefits, whichever first occurs; or

   • where benefits have been paid under the provision of the Policy, within 1 year of the date on which Co-operators Life terminates the payment of benefits.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision and in no event shall it be extended to each and every monthly payment accruing after the date(s).
Accessing your records
As required by legislation, for insured benefits, if you reside in a province where legislation requires that you have the right to obtain a copy of your enrollment form or application for insurance and any written statements or other record not otherwise part of the application that you provided to Co-operators Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the master policy. The first copy will be provided at no cost to you but a fee will be charged for subsequent copies. All requests for copies of documents should be directed to our Group Client Service Centre.

How do I submit a claim?
Claim forms are available from your employer or from our website www.nebsnorth.com.

Employee and Dependent Life, Short Term Disability (Weekly Indemnity), and Long Term Disability claims should be sent to:

Manager, Group Benefits Plans
Northern Employee Benefits Services
#700, 5201 50th Avenue
Yellowknife, N.T.
X1A 3S9

Upon completion, Extended Health Care, Vision Care and Dental Care claims should be sent to:

Group Claims Department
The Co-operators
1920 College Avenue
REGINA, Saskatchewan
S4P 1C4

Prescription drug claims can be submitted electronically if your pharmacy has the capability to submit drug claims online. If your pharmacy does not accept online transmission please complete a standard Extended Health Care claim form and submit it to Co-operators Life.

Extended health care claim forms must be accompanied by receipts which give sufficient detail to assist in the settlement of the claim. Dental claim forms must be completed by you and your dentist, and a separate form is required for each person seeing the dentist.

Dental Claims and Dental treatment plans for pre-determination may be submitted electronically if your dental office has the capability to submit claims online. If your dental office does not accept online transmission please complete a standard Dental Association claim form and mail it to The Co-operators.

Visit www.cooperators.ca and click on Group >Group Benefits for claim forms, cost control tips, answers to frequently asked questions, links to health & wellness sites and much more.
Conversion Privilege

On termination of your group life insurance prior to age 65, you and/or your spouse may obtain an individual policy with the Co-operators Life Insurance Company without providing evidence of good health on the ordinary life plan, limited payment life, term to age 65, or one year term plan (non-renewable) at The Co-operators regular rates.

This individual policy will be limited to the lesser of $200,000.00, or the difference between the amount of insurance at the time of your termination and the amount of insurance for which you are eligible under a new group contract, at the time you are exercising your right to convert. If insurance terminates on your 65th birthday, you shall only be entitled to have issued a whole life plan. The individual policy will be issued only if application is made within 31 days after your termination.

Where you (or your spouse, if your spouse has Optional Life insurance) has not converted insurance under this plan and where you (or your spouse, if insured) dies within the 31 days allowed for conversion, the amount of basic life insurance (and optional life insurance if applicable) eligible for conversion, will be payable under this plan.

Note: Elected councillors and appointed board members are not eligible for the conversion privilege.

THE INFORMATION CONTAINED IN THIS BOOKLET IS FOR GUIDANCE ONLY. PLEASE KEEP THIS IMPORTANT DOCUMENT IN A SAFE PLACE FOR FUTURE REFERENCE.

We ask that you review the information contained in this booklet to obtain an understanding of your group benefits program. The master Policy G. 799 and Plan Text G. 799 issued by Co-operators Life Insurance Company to the Policyholder/Plan Sponsor Northern Employee Benefits Services 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 Policy or the Plan Text, the terms and conditions of the Policy and Plan Text prevail.

The Extended Health and Vision Care and Dental Care Plans are self-insured. This means that the Plan Sponsor, Northern Employee Benefits Services is responsible for all of the obligations to the Employees and/or other Covered Persons including the payment of all benefits under the Extended Health and Vision Care and Dental Plans.

Co-operators Life is only the administrator of the Extended Health and Vision Care and Dental Care Plans. It has no liability whatsoever to Employees and/or other Covered Persons including any liability for benefits provided under the Extended Health and Vision Care and Dental Care Plans.
SCHEDULE OF BENEFITS

This Schedule of Benefits must be read together with the benefits described in this booklet.

Basic Life Insurance

Option 1

Benefit Formula: 300% of Annual Salary
Rounding Rule: Up to the next multiple of $1,000

Amount of Insurance:
Maximum $300,000

Reduction Rules:
At Age 65
Reduce By 50%
To A Maximum Of $150,000

At Age 70
Reduce By 25% of amount in effect prior to your 65th birthday
To A Maximum Of $75,000

Survivor Benefit: No Coverage

Termination Age: 75

Total Disability Life Waiver: Basic Life premiums are waived after 4 months of Total Disability retroactive to the date of Total Disability.

Life Total Disability Waiver Termination Age: 65

Basic Life Insurance

Option 2

Benefit Formula: 150% of Annual Salary
Rounding Rule: Up to the next multiple of $1,000

Amount of Insurance:
Maximum $150,000
Schedule of Benefits

Reduction Rules:

At Age 65
Reduce By 50%
To A Maximum Of $75,000

At Age 70
Reduce By 25% of amount in effect prior to your 65th birthday
To A Maximum Of $37,500

Survivor Benefit: No Coverage

Termination Age: 75

Total Disability Life Waiver: Basic Life premiums are waived after 4 months of Total Disability retroactive to the date of Total Disability.

Life Total Disability Waiver Termination Age: 65

Basic Life Insurance

Option 3 – Available to elected councillors and appointed board members if the employer has chosen this option.

Benefit Formula: Flat amount of $100,000

Amount of Insurance:
Flat amount $100,000

Reduction Rules:
At Age 65
Reduce By 50%
To A Maximum Of $50,000

At Age 70
Reduce By 25% of amount in effect prior to your 65th birthday
To A Maximum Of $25,000

Survivor Benefit: Not Available

Optional Life: Not Available

Termination Age: 75
### Dependent Life Insurance

<table>
<thead>
<tr>
<th></th>
<th>Spouse</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount of Insurance:</strong></td>
<td>$10,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Pre-natal Benefit:</strong></td>
<td>No Coverage</td>
<td></td>
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<tr>
<td><strong>Termination Age:</strong></td>
<td>70</td>
<td></td>
</tr>
<tr>
<td><strong>Total Disability Life Waiver:</strong></td>
<td>Same as Basic Life</td>
<td></td>
</tr>
</tbody>
</table>

### Long Term Disability Benefits (LTD)

#### Option 1

| **Benefit Formula:**   | 60% of Monthly Salary |
| **Rounding Rule:**     | Up to the next multiple of $1 |
| **Amount of Insurance:** | $6,600/month |
| **All Source Maximum** | 85% of Net Salary |
| **Benefit will not exceed the All Source Maximum.** |
| **24 Hour Coverage:**  | Yes |
| **Elimination Period:** |  |
| **Accident**           | 119 Days |
| **Sickness**           | 119 Days |
| **Own Occupation Period:** | 24 Months from the Date of Disability; Any & All thereafter |
| **Benefit Duration:**  | To Age 65 |
| **Recurrent Total Disability:** | 6 Months |
| **Tax Status:**        | Non-taxable |
| **Termination Age:**   | 65 |
| **Total Disability Waiver of Premium:** | Long Term Disability premiums are waived when LTD benefits begin. Total Disability waiver of premium terminates at age 65. |
Long Term Disability Benefits (LTD)

Option 2

- **Benefit Formula**: 70% of Monthly Salary
- **Rounding Rule**: Up to the next multiple of $1
- **Amount of Insurance**: Maximum
  - $6,600/month
- **All Source Maximum**: 85% of Gross Salary
  - Benefit will not exceed the All Source Maximum.
- **24 Hour Coverage**: Yes
- **Elimination Period**:
  - Accident: 119 Days
  - Sickness: 119 Days
- **Own Occupation Period**:
  - 24 Months from the Date of Disability;
  - Any & All thereafter
- **Benefit Duration**: To Age 65
- **Recurrent Total Disability**: 6 Months
- **Tax Status**: Taxable
- **Termination Age**: 65
- **Total Disability Waiver of Premium**: Long Term Disability premiums are waived when LTD benefits begin. Total Disability waiver of premium terminates at age 65.
- **CPP Offset**: Primary
- **Pre-existing Exclusion Applies**: Yes
## Short Term Disability (Weekly Indemnity)

### Option 1

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Formula:</td>
<td>60% of Weekly Salary</td>
</tr>
<tr>
<td>Rounding Rule:</td>
<td>Up to the next multiple of $1</td>
</tr>
<tr>
<td>Amount of Insurance:</td>
<td></td>
</tr>
<tr>
<td>Benefit Maximum</td>
<td>$1,535/week</td>
</tr>
<tr>
<td>All Source Maximum:</td>
<td>85% of Net Salary</td>
</tr>
<tr>
<td>Benefit will not exceed the All Source Maximum.</td>
<td></td>
</tr>
<tr>
<td>24 Hour Coverage:</td>
<td>Yes</td>
</tr>
<tr>
<td>STD Plan:</td>
<td></td>
</tr>
<tr>
<td>Accident</td>
<td>1 Day(s)</td>
</tr>
<tr>
<td>Sickness</td>
<td>8 Day(s)</td>
</tr>
<tr>
<td>1st Day Hospital Coverage:</td>
<td>No</td>
</tr>
<tr>
<td>Benefit Period:</td>
<td>17 weeks from date of Total Disability</td>
</tr>
<tr>
<td>Recurrent Total Disability:</td>
<td>4 weeks</td>
</tr>
<tr>
<td>STD Week:</td>
<td>5 days</td>
</tr>
<tr>
<td>Tax Status:</td>
<td>Non-taxable</td>
</tr>
<tr>
<td>Termination Age:</td>
<td>65</td>
</tr>
<tr>
<td>Total Disability Waiver of Premium:</td>
<td>Short Term Disability premiums are waived</td>
</tr>
<tr>
<td></td>
<td>when Benefits begin. Total Disability waiver</td>
</tr>
<tr>
<td></td>
<td>of premium terminates at age 65.</td>
</tr>
<tr>
<td>CPP Offset:</td>
<td>Primary</td>
</tr>
<tr>
<td>Pre-existing Exclusion Applies:</td>
<td>No</td>
</tr>
</tbody>
</table>
### Short Term Disability (Weekly Indemnity)

#### Option 2

<table>
<thead>
<tr>
<th>Benefit Formula:</th>
<th>70% of Weekly Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rounding Rule:</td>
<td>Up to the next multiple of $1</td>
</tr>
</tbody>
</table>

| Amount of Insurance:   |                                 |
|------------------------|                                 |
| Benefit Maximum        | $1,535/week                     |

| All Source Maximum:    |                                 |
|------------------------|                                 |
| Benefit will not exceed the All Source Maximum. | |

| 24 Hour Coverage:      | Yes                              |

| STD Plan:              |                                 |
|------------------------|                                 |
| Accident               | 1 Day(s)                         |
| Sickness               | 8 Day(s)                         |

| 1st Day Hospital Coverage: | No |

| Benefit Period:           | 17 weeks from date of Total Disability |

| Recurrent Total Disability: | 4 weeks |

| STD Week:                 | 5 days  |

| Tax Status:               | Taxable |

| Termination Age:          | 65      |

| Total Disability Waiver of Premium: | Short Term Disability premiums are waived when Benefits begin. Total Disability waiver of premium terminates at age 65. |

| CPP Offset:               | Primary |

| Pre-existing Exclusion Applies: | No |
Schedule of Benefits

Extended Health Care Benefits (EHC)

Calendar Year Deductible:
- Hospital Expenses: $0
- Emergency Out of Canada Expenses: $0
- Vision Care Expenses: $0
- All Other Health Expenses:
  - Single: $0
  - Family: $0

Co-payment Level:
- Hospital Expenses: 100%
- Emergency Out of Canada Expenses: 100%
- Vision Care Expenses: 100%
- Therapeutic Expenses: 100%
- Diabetic Monitoring & Administration Equipment: 100%

Drug Formulary
- Pay-Direct Card Plan: Premier

Pay-Direct Card Plan:
- Prescription Drugs: 100%
- Prescription Deductible: N/A
- Provincial Formulary Only: No
- Contraceptive Drugs: Yes
- Antismoking Drugs: $300/Lifetime
- Fertility Drugs: No
- All Other Extended Health Care Expenses: 100%

Maximums:
- Emergency Out of Canada and Travel Benefits Plus: $1,000,000/any one injury or sickness
- EHC Calendar Year: Unlimited/Individual
- Emergency Out of Canada Duration: 90 Days

Extended Health Care Benefit Maximums:
- Hospital Room Accommodation: Semi-private
- Hospital Room Daily Dollar Maximum: Reasonable & Customary
- Convalescent Hospital: $20/Day & 120 Days
- Home Nursing: $10,000/3 Years

Paramedical Practitioners:
- Osteopath/Chiropractor/Podiatrist: $750/Year combined
- Physiotherapist/Massage Therapist: $750/Year combined
- Naturopath/Acupuncturist: $750/Year combined
- Psychologist/Social Worker/Licensed Councillor: $750/Year combined
- Speech Therapist/Audiologist: $750/Year combined
- Nutritionist/Dietician: $750/Year combined
**Schedule of Benefits**

**Eye Examinations:**
- **Maximum**
  - Adults: 1 Visit/2 calendar years
  - Child: 1 Visit/1 calendar year

**Vision Care Benefit:**
- **Maximum**: $350
- **Adult/Child Frequency**: 24/12 Months
- **Tinting of Glasses Included**: No

**Laser Eye Surgery**: $1,500 per lifetime

**Ambulance Services Included**: Yes

**Diabetic Supplies**: Unlimited

- Diabetic monitoring and admin equipment: $500 per lifetime
- Orthopedic Shoes or Orthotics: $300/24 months
- Hearing Aids: $1,000/5 years
- Speech Aids: No Coverage
- Therapeutic Equipment: $1,000 per Piece of Equipment
- Northern Medical Transportation: $125 one way or $250 two way
- Hair Pieces: $200/Lifetime
- External Mastectomy Forms: 1/60 Months
- Surgical Brassieres: 2/Year
- Prosthetic Socks: 5 pair per year
- Graduated Compression Hose: 2 pair per year

**Survivor Benefit**: 1 Year

**Termination Age for All Other EHC Benefits**: 70

**Termination Age for Emergency Out of Canada**: 65
Schedule of Benefits

Dental Care Benefits

Calendar Year Deductible:
- Single: $25
- Family: $50

Co-insurance Levels:
- Plan A:
  - Basic Restorative Services: 100%
  - Endodontic & Periodontic Services: 100%
- Plan B:
  - Major Restorative Services: 60%
- Plan C:
  - Orthodontic Services: 50%

Dental Care Benefit Maximums:
- Plan A - Basic Restorative Services, and
- Plan A - Endodontic & Periodontic Services, and
- Plan B - Major Restorative Services
  - Combined maximum: $2,000/person/Year
- Plan C: Orthodontic Services: $3,500/Lifetime/Child

Dental Fee Guide:
- Current Year

Fee Guide Type:
- General Practitioner & Specialists

Frequency Limits:
- Recall Exams: 2/12 Months
- Cleaning: 2/12 Months
- Bitewing X-rays: 2/12 Months
- Fluoride Treatment: 2/12 Months
- Child Age Limit: 21
  - Adult Fluoride Included: Yes, 1/12 months
- Complete X-rays: 1/24 Months
- Complete Exam: 1/36 Months
- Reline/Repair Dentures: 1/36 Months
- Oral Hygiene Instruction: 1/12 Months
- Periodontic Treatments: 8 Units/per year
### Schedule of Benefits

**Other Dental Information:**
- Crowns and Onlays
- Replacement After: 5 Years
- Full/Partial/Removable Denture or Fixed Bridgework Replacement After: 5 Years
- Major Dental includes Missing Tooth Clause: Yes

**Orthodontic Services**
- Dependent Children Only (under 19)

**Survivor Benefit:**
- 1 Year

**Termination Age:**
- 70

### Optional Life Insurance

- **Employee &/or Spouse**
  - **Amount of Insurance:** An Employee &/or Spouse may select any Amount of Insurance, in units of $10,000 from a minimum of $10,000 to a maximum of $200,000 for the Employee and a maximum of $200,000 for the Spouse.

- **Dependent Parent**
  - **Amount of Insurance:** A Dependent Parent may select a $5,000 Amount of Insurance.

- **Termination Age:** 70

- **Total Disability Life Waiver:** Same as Basic Life
BASIC GROUP LIFE INSURANCE

The amount of insurance below will be payable to your beneficiary upon your death.

Option 1
Each employee under 65 years of age
3 times the employee's annual salary to a maximum benefit of $300,000 rounded to the next highest $1,000 if not already a multiple thereof.

Each employee 65 years of age to 70 years of age
50% of the amount in effect prior to your 65th birthday.

Each employee 70 years of age or older
25% of the amount in effect prior to your 65th birthday to a maximum of $75,000.

Option 2
Each employee under 65 years of age
1.5 times the employee's annual salary to a maximum benefit of $150,000 rounded to the next highest $1,000 if not already a multiple thereof.

Each employee 65 years of age to 70 years of age
50% of the amount in effect prior to your 65th birthday.

Each employee 70 years of age or older
25% of the amount in effect prior to your 65th birthday to a maximum of $37,500.

Option 3
Each elected councillor and appointed board member under 65 years of age.
$100,000 benefit

Each elected councillor and appointed board member 65 years of age to 70 years of age
50% of the amount in effect prior to your 65th birthday.

Each elected councillor and appointed board member 70 years of age and over
25% of the amount in effect prior to your 65th birthday to a maximum of $25,000.
Basic Group Life Insurance

* Your salary means your regular annual salary, not including bonuses, commissions, overtime, money's paid in lieu of holidays or for travelling expenses, subsistence allowance, housing allowance, settlement allowance, living allowance, honorarium, fees or any other moneys paid in addition to the Employee's ordinary salary or wages.

Total Disability Waiver of Premium

Note: Elected councillors and appointed board members are not eligible for total disability waiver of premium.

Should you become totally and continually Totally Disabled (as that term is defined in the Policy) for more than four (4) months prior to age 65, the amount of your life insurance will continue without payment of premiums while you remain totally disabled. Satisfactory proof of total disability must be submitted to The Co-operators within 12 months from the date of Total Disability and thereafter, upon request by The Co-operators. Your life insurance coverage and waiver will terminate when you reach age 65 or recover, whichever occurs first.

Recurrent Total Disability

Where you become Totally Disabled again from the same or related cause as those for which premiums were waived under the life waiver provision of the master policy and such Total Disability recurs within 6 months of cessation of the waiver of premiums, upon receipt of proof, Co-operators Life will waive the waiver of premium benefit waiting period.

All such recurrences will be considered a continuation of the same Total Disability. Your amount of insurance on which premiums were previously waived will be reinstated.

Living Assistance Benefits

The living benefit program is available as an advance payment of life insurance to help meet the medical or other health and welfare expenses of employees (including Elected Councillors and Appointed Board Members) who are diagnosed as terminally ill prior to the age of 65 and while insured under the policy.

Application for this benefit must be approved by your employer/plan administrator and The Co-operators will confirm that medical evidence meets the program's requirements before approving payment.

The amount of money available as a living benefit payment is 50% of your group life insurance benefit, to a maximum of $50,000.

The living benefit is at the sole discretion of The Co-operators and is not a contractual obligation.

Submitting a Claim

The time limit within which a group life insurance claim must be made is 180 days from the date of loss.

Exclusions

There are no suicide exclusions for the Basic Group Life Insurance benefit.
Termination Age

Your basic group life insurance benefit terminates at age 75.
DEPENDENTS INSURANCE

This benefit provides life insurance coverage for your spouse and dependent children. The amount of the benefit is:

Spouse ............ $10,000

Child ............... $5,000

Total Disability Waiver of Premium

If you are totally disabled and the premiums for your basic life insurance coverage are being waived, then premiums for the dependent insurance will also be waived, but only so long as this benefit and your employer’s coverage under this benefit remains in force.

Exclusions

There are no suicide exclusions for the Dependents Insurance benefit.

Termination Age

Your dependents insurance terminates when you reach age 70.
LONG TERM DISABILITY

The purpose of this benefit is to provide coverage should you become totally disabled as the result of an accidental injury or illness and are unable to work at your own occupation for wage or profit.

Your benefit is determined as follows:

**Option 1**
Each employee ... 60% of monthly salary rounded to the next highest $1.00 if not already a multiple thereof to a maximum non-taxable monthly benefit of $6,600, or 85% of your pre-disability net salary, whichever is less.

**Option 2**
Each employee ... 70% of monthly salary rounded to the next highest $1.00 if not already a multiple thereof to a maximum taxable monthly benefit of $6,600, or 85% of your pre-disability gross salary, whichever is less.

Your salary is your regular monthly earnings paid by your Employer, exclusive of bonuses, overtime earnings and commissions or money's paid in lieu of holidays, or travelling expenses, subsistence allowance, housing allowance, settlement allowance, living allowance, honorarium, fees or any other moneys paid in addition to your ordinary salary or wages.

Benefits will commence on the later of:
- the 120th day of continuous/consecutive disability, or
- the day following the end of a period during which you are receiving Short Term Disability Benefits.

You are eligible for benefits for a 24 month period from the date of disability if you are unable to perform the usual and customary duties of your occupation. Thereafter, benefits will continue only if you are unable to perform the duties of any occupation.

In no case shall a benefit be paid beyond:
- the date of your 65th birthday, or
- the date you are no longer totally disabled, or
- retirement, or the date you withdraw or elect to receive pension funds, or
- the date you engage in any work or occupation other than rehabilitative employment, or
- the date you fail to furnish satisfactory evidence of total disability or refuse to submit to a medical examination by a physician chosen by the insurance company, or
- the date you refuse to participate in a rehabilitation program,
whichever first occurs.

Successive periods of disability arising from the same or related cause and separated by less than six consecutive months will be treated as one period of continuous total disability. The Monthly Benefit payable will be based on the Employee’s Monthly Salary in effect the original date of Total Disability.
**Long Term Disability**

**Benefit Adjustment**

At the time of a claim, your Long Term Disability benefit will be reduced by any disability benefits you are entitled to receive from the Workers' Compensation Act or Canada Pension Plan and any criminal injuries compensation legislation. The reduction will not include any additional amounts payable for dependents or cost of living increases.

If necessary, your benefit will be further adjusted so that your total income will not exceed 85% of your pre-disability gross salary (net salary if your benefit is non-taxable). This applies to disability benefits from any other source including: pension plan; employer funded salary replacement; automobile insurance act; other insurance plan whether group or association; damages for loss of income which are payable from any legal action; employment income other than from an approved rehabilitation program; and severance.

**Rehabilitation Program**

Based on a determination made by The Co-operators, a rehabilitation program may be provided to you which could include: assessment (medical, psychological, vocational evaluation), treatment (medical, psychological, vocational intervention, including various programs of therapy), employment (work trial, modified/ full or part-time work), services (training strategies and work related activities expected to enhance your ability to return to work or secure employment) and a rehabilitation benefit.

The Co-operators will have the sole right and discretion in determining whether a rehabilitation program will be provided to you and the services provided as part of that program. If you do not participate in a rehabilitation program provided either by The Co-operators or by another party and approved by The Co-operators (i.e. any worker’s compensation act or similar statute, auto plan benefits, Canada/Quebec Pension Plan) or The Co-operators withdraws approval of your program, then your disability/rehabilitation benefits under this policy will cease.

While you participate in the rehabilitation program your disability benefit will continue, but will be reduced by 50% of any rehabilitative earnings (total earnings from your rehabilitation employment if your benefit is taxable, total earnings less income tax, EI, CPP/QPP if your benefit is non-taxable). Your benefit may be further reduced so that your rehabilitative earnings plus your disability benefit do not exceed 100% of your pre-disability income (gross if your benefit is taxable, net if your benefit is non-taxable).

Any rehabilitation program will not extend beyond the end of your own occupation period. Nothing in the rehabilitation program or provision will create any basis for any extension of the own occupation period.

**Third Party Liability**

If you become totally disabled due to an injury or disease for which a third party is, or may be legally liable, benefits will be paid when you sign (and submit to The Co-operators) a Reimbursement Agreement.

You will be required to reimburse the insurance company for benefits received in accordance with the terms and conditions stated in the Reimbursement Agreement.
You must obtain the written consent of the insurance company before compromising or settling the action or cause of action with the third party. Failure to do so may disentitle you to any future benefits under this policy.

**Total Disability Waiver of Premium**

Premiums will be waived while you are receiving disability benefits commencing with the first premium that falls due after the first benefit payment is eligible to be made.

**Exclusions**

a. No benefit will be payable for any disability resulting from or caused by:
   - intentionally self-inflicted injury, while sane or insane;
   - insurrection, war or hostilities of any kind;
   - participating in a riot or civil commotion;
   - injury occurring while committing or attempting to commit a criminal offense;
   - medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation of an organ or tissue will be covered;
   - use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment;
   - injury or sickness for which a third party is liable, except as provided for in the Third Party Liability section.

b. No benefit will be payable for any disability if you are imprisoned or if you are not under continuous care and treatment of a physician who is certified by the Royal College of Physicians and Surgeons in a speciality appropriate to your sickness or injury.

c. No benefits will be payable during any period that you are on maternity leave, parental leave, compassionate leave, educational leave or any other leave of absence, however:

   During pregnancy - prior to scheduled maternity leave - provided premiums are paid, benefits may be provided for eligible disabilities that satisfy the definition of “Total Disability” in the master policy and are otherwise eligible and that commence prior to the date of the scheduled maternity leave with the payment of benefits to commence at the end of the elimination period.

   The elimination period shall begin on the date of disability. Benefits for such eligible disabilities will cease on the date of your scheduled maternity leave or the date of birth, whichever is earlier. A scheduled maternity leave is deemed to commence on the date agreed upon by you and your employer. If a child is born prior to the date upon which maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.
Long Term Disability

During scheduled maternity, parental or compassionate leave - provided premiums are paid, benefits may be provided for eligible disabilities that satisfy the definition of "Total Disability" in the master policy and are otherwise eligible and that commence during the period of leave, with the payment of benefits to commence on the later of the end of the elimination period or your scheduled return to work date. The elimination period shall begin on the date of disability. A scheduled maternity, parental or compassionate leave is deemed to commence on the date agreed upon by you and your employer. If a child is born prior to the date upon which a maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

During approved educational leave of absence - should you be considered disabled in accordance with the terms of the master policy during the approved leave of absence, benefits will not be payable until the elimination period has been satisfied. The elimination period will commence the date you were scheduled to return to work. The income benefit payable will be based on the monthly salary in effect the day before the leave of absence commenced.

d. No further benefits will be payable from the date you refuse to participate in any rehabilitation program approved by The Co-operators.

Pre-existing Condition Limitation

Pre-existing condition means a sickness or injury for which you sought medical investigation, diagnosis, treatment, care medication or medical advice, or for which there were symptoms which would have caused a person to seek medical investigation, diagnosis, care, treatment, medication or medical advice within the 90 day period immediately prior to becoming insured under the long term disability benefit.

No monthly benefits will be payable for any period of total disability which results directly or indirectly from a pre-existing condition, unless:

• you have not required treatment, medication, or medical advice for the condition for a continuous period of at least 90 days immediately following the effective date of your long term disability coverage, or

• you have been insured under this long term disability plan for at least 12 months (from the date your insurance became effective) and you have not been absent from work during the 12 month period as a result of the pre-existing condition. Time away from work up to 10 cumulative working days during the 12 month period will be interpreted as not being absent from work.

Submitting a Claim

The time limit within which a Long Term Disability claim must be made is 90 days from the date the insurance company is liable.

Termination Age

Your Long Term Disability benefit terminates at age 65.
SHORT TERM DISABILITY

Check with your EMPLOYER to find out if Short Term Disability coverage is offered by the NEBS employer for whom you work.

The purpose of this benefit is to provide coverage should you become disabled as a result of injury or sickness, require the attendance of a specialist, and are unable to perform the usual and customary duties of your occupation.

Your benefit is determined as follows:

Option 1
Each employee ... 60% of your weekly salary rounded to the next highest $1.00 if not already a multiple thereof to a maximum non-taxable weekly benefit of $1,535, or 85% of your pre-disability net salary, whichever is less.

Option 2
Each employee ... 70% of your weekly salary rounded to the next highest $1.00 if not already a multiple thereof to a maximum taxable weekly benefit of $1,535, or 85% of your pre-disability gross salary, whichever is less.

Your benefit will commence on the 1st day if disability is due to injury and the 8th day if disability is due to sickness.

Benefits will not be paid beyond:

- the 17th week from the date of disability, or
- the date of your 65th birthday, or
- retirement, or the date you withdraw or elect to receive pension funds, or
- the date you engage in any work or occupation,
- the date you fail to furnish satisfactory evidence of total disability or refuse to submit to a medical examination by a physician chosen by the Insurance Company, whichever first occurs.

Successive periods of disability arising from the same or related cause and separated by less than four consecutive weeks will be treated as one period of continuous total disability. The Weekly Benefit payable will be based on the Employee’s Weekly Salary in effect the original date of Total Disability.
Short Term Disability

Benefit Adjustment

At the time of a claim, your Short Term Disability benefit will be reduced by any disability benefits you are entitled to receive from the Workers' Compensation Act or Canada Pension Plan and any criminal injuries compensation legislation. The reduction will not include any additional amounts payable for dependents or cost of living increases.

If necessary, your Short Term Disability benefit will be further adjusted so that your total income will not exceed 85% of your pre-disability gross salary (net salary if your benefit is non-taxable). This applies to disability benefits from any other source including: pension plan; automobile insurance act; employer funded salary replacement; other insurance plan whether group or association; damages for loss of income which are payable from any legal action; employment income other than from an approved rehabilitation program; and severance.

Rehabilitation Program

Based on a determination made by The Co-operators, a rehabilitation program may be provided to you which could include: assessment (medical, psychological, vocational evaluation), treatment (medical, psychological, vocational intervention, including various programs of therapy), employment (work trial, modified/ full or part-time work), services (training strategies and work related activities expected to enhance your ability to return to work or secure employment) and a rehabilitation benefit.

The Co-operators will have the sole right and discretion in determining whether a rehabilitation program will be provided to you and the services provided as part of that program. If you do not participate in a rehabilitation program provided either by The Co-operators or by another party and approved by The Co-operators (i.e. any worker’s compensation act or similar statute, auto plan benefits, Canada/Quebec Pension Plan) or The Co-operators withdraws approval of your program, then your disability/rehabilitation benefits under this policy will cease.

While you participate in the rehabilitation program your disability benefit will continue, but will be reduced by 50% of any rehabilitative earnings (total earnings from your rehabilitation employment if your benefit is taxable, total earnings less income tax, EI, CPP/QPP if your benefit is non-taxable). Your benefit may be further reduced so that your rehabilitative earnings plus your disability benefit do not exceed 100% of your pre-disability income (gross if your benefit is taxable, net if your benefit is non-taxable).

Any rehabilitation program will not extend beyond 17 weeks from the date of disability. Nothing in the rehabilitation program or provision will create any basis for any extension of the benefit period.

Third Party Liability

If you become totally disabled due to an injury or disease for which a third party is, or may be legally liable, benefits will be paid when you sign (and submit to The Co-operators) a reimbursement agreement.

You will be required to reimburse the insurance company for benefits received in accordance with the terms and conditions stated in the reimbursement agreement.
Short Term Disability

You must obtain the written consent of the insurance company before compromising or settling the action or cause of action with the third party. Failure to do so may disentitle you to any future benefits under this policy.

Total Disability Waiver of Premium

Premiums will be waived while you are receiving disability benefits commencing with the first premium that falls due after the first benefit payment is eligible to be made.

Exclusions

No benefit will be payable for:

a. any period of disability covered by The Workers’ Compensation Act or any similar legislation.

b. any disability resulting from or caused by:

- intentionally self-inflicted injury, while sane or insane;
- insurrection, war or hostilities of any kind, whether declared or not;
- participating in a riot or civil commotion;
- injury occurring while committing or attempting to commit a criminal offense;
- medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation of an organ or tissue will be covered;
- use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment.

c. any disability if:

- as a result of injury or sickness for which a third party is liable, except as provided for in the Third Party Liability section;
- you are not under the continuous care and treatment of a physician who is certified by the Royal College of Physicians and Surgeons in a speciality appropriate to your sickness or injury;
- you are imprisoned;
- you are on maternity leave, parental leave, compassionate leave, educational leave or any other leave of absence, however:
During pregnancy - prior to scheduled maternity leave - provided premiums are paid, benefits may be provided for eligible disabilities that satisfy the definition of "Total Disability" in the master policy and are otherwise eligible and that commence prior to the date of the scheduled maternity leave with the payment of benefits to commence at the end of the elimination period. The elimination period shall begin on the date of disability. Benefits for such eligible disabilities will cease on the date of your scheduled maternity leave or the date of birth, whichever is earlier. A scheduled maternity leave is deemed to commence on the date agreed upon by you and your employer. If a child is born prior to the date upon which maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

During scheduled maternity, parental or compassionate leave - provided premiums are paid, benefits may be provided for eligible disabilities that satisfy the definition of "Total Disability" in the master policy and are otherwise eligible and that commence during the period of leave, with the payment of benefits to commence on the later of the end of the elimination period or your scheduled return to work date. The elimination period shall begin on the date of disability. A scheduled maternity, parental or compassionate leave is deemed to commence on the date agreed upon by you and your employer. If a child is born prior to the date upon which a maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

During approved educational leave of absence - should you be considered disabled in accordance with the terms of the master policy during the approved leave of absence, benefits will not be payable until the elimination period has been satisfied. The elimination period will commence the date you were scheduled to return to work. The income benefit payable will be based on the monthly salary in effect the day before the leave of absence commenced.

d. No further benefits will be payable from the date you refuse to participate in a rehabilitation program which is considered appropriate by the Insurance Company.

**Submitting a Claim**

The time limit within which a Short Term Disability claim must be made is 90 days from the date the insurance company is liable.

**Termination Age**

Your short term disability benefit terminates at age 65.
EXTENDED HEALTH CARE

Check with your EMPLOYER to find out if extended health care coverage is offered by the NEBS employer for whom you work. If your employer offers this coverage, you have the choice whether to participate.

This benefit has been designed to provide additional hospital and medical benefits resulting from the treatment of illness or injury which are not assumed under a province’s or territory's basic medical plan. You and your dependents must have coverage under the provincial health care plan in your province of residence. Coverage is provided to both you and your eligible dependents.

Deductible

There will be no cash deductible on any covered charges incurred.

Co-Coverage

The Co-operators will pay 100% of the covered charges.

Coverage Maximum

The maximum reimbursement per calendar year will be unlimited, except as defined under the benefits section.

For any one out-of-country accident or illness the maximum reimbursement will be $1,000,000 regardless of the number of years for which expenses are incurred.

Pre-determination

Medical expenses which are likely to exceed $400 should be submitted to The Co-operators (except prescription drugs) for approval. If the pre-determination is not obtained, The Co-operators reserves the right to reimburse you on the basis of its recommendations had the pre-determination been submitted.

Benefits

The plan covers the following:

a. Emergency out-of-country

   Charges for emergency care while travelling outside of Canada including:
   • charges for ward accommodation
   • charges by a licensed physician
   • charges for services and supplies furnished during hospitalization
   • charges for x-rays and lab tests related to emergency care rendered without hospitalization

   These charges are not subject to the deductible or co-coverage amounts. All charges must be reasonable and customary for the area in which the expense was incurred and must be eligible at least in part for reimbursement under your government health insurance plan.
Extended Health Care

If you are referred by a physician to an acute care hospital outside of Canada for care for which there is no medically sufficient alternative in Canada and prior approval was obtained from your government health insurance plan, the charges listed above are covered.

If you have a dependent who is a full-time student outside of Canada, reimbursement will be limited to what would have been reimbursed if the services had been provided in your own province or territory of residence.

Travel Benefits Plus
The following additional travel benefits are provided if:
- the loss is a covered out-of-country or out-of-province medical emergency or
- the loss is a covered medical emergency that occurred within the covered persons province of residence at a location in excess of 500 kilometres from the covered person’s home

Expenses incurred out of Canada, accumulate to the emergency Out-of-Canada maximum as indicated in the schedule of benefits. Expenses incurred in Canada, accumulate to the overall extended health care plan maximum as indicated in the schedule of benefits.

- Emergency Medical Transportation - coverage is provided for emergency medical transportation to the nearest hospital where treatment is available. If the covered person is travelling outside Canada, coverage is also provided for the cost of emergency medical transportation to a hospital in Canada when the covered person is assessed as medically transportable, provided transportation has been pre-approved and arranged by Co-operators Life.

- Qualified Medical Attendant - reasonable fees, including airfare, accommodation, and meal expenses, charged by a medical attendant other than a relative who accompanies the covered person during a return flight on a commercial airline, when required by the attending physician and when pre-approved and arranged by Co-operators Life.

- Return of Family Members – in the event that arrangements for pre-paid transportation to the covered person’s province of residence were missed due to a covered Injury or Sickness, the cost of one-way economy fares, less any credit for unused tickets, for the covered person and dependents. In addition, when the covered person is transported by air ambulance or commercial stretcher, one-way economy airfare to return the dependents home, provided travel is pre-approved and arranged by Co-operators Life. Reasonable and customary expenses, including return or round-trip economy class airfare, for an escort to accompany dependent children home, when necessary and when pre-approved by Co-operators Life.

- Bedside Attendance - reimbursement for round-trip economy airfare by the most direct route via a common carrier in the event that the covered person becomes hospitalized as a result of a covered injury or sickness, if the attending physician advises that the covered person requires the attendance of a family member or close friend.
Return of Vehicle – reimbursement of the reasonable and customary amount to a maximum of $3,000 for a commercial agency to return a vehicle to the covered person’s home or, if a rental vehicle was used, to the nearest rental agency, in the event that the covered person is unable, for reasons of a covered illness or injury, to return home with the vehicle used for the journey, or:

If the covered person was air evacuated, reimbursement of the cost for one-way economy class airfare to the city from which an air evacuation commenced in order to retrieve the vehicle. If the covered person was air evacuated with another covered person, then that person is also eligible for one-way economy class airfare to the city from which the air evacuation commenced. Reimbursement is limited to a combined maximum of $3,000.

Out-of-Pocket Allowance - reimbursement up to a maximum of $2,500 for reasonable and customary living expenses, child care, essential telephone calls and taxi fares incurred by the covered person or by persons remaining with the covered person while the covered person is hospitalised as an inpatient.

Repatriation Expenses - in the event that a covered person dies from a covered injury or sickness, Co-operators will pay up to a maximum of $10,000 for:
- cremation expenses at the place of death, or
- reasonable and customary expenses incurred in preparing the deceased for burial and shipment to the province of residence provided the deceased does not have any other repatriation benefit under the policy or any other insurance policy (no reimbursement is provided for the cost of the casket)

Identification of Deceased – in the event that a covered person dies from a covered injury or sickness while travelling alone and if required by authorities, reimbursement of round-trip economy airfare by the most direct route via a common carrier for a family member to travel to identify the deceased prior to release of the body. If you are travelling alone, we recommend that you register with the Canadian embassy in the country you are visiting.

b. Hospital Board and Room Charges

Charges made by a hospital for services and supplies which are necessary for the medical treatment of sickness or injury, including charges for a semi-private room, but not when occupied primarily for the purposes of custodial care. Charges for these services are not subject to the deductible or co-coverage amounts.

c. Convalescent Hospital and Nursing Services

Charges for chronic and/or convalescent hospitals are limited to $20.00 per day to a maximum stay of 120 days, but are not eligible if the covered person was hospitalized in either a chronic and/or convalescent hospital on the effective date of your coverage.

Charges for out-of-convalescent hospital services of a registered nurse or nursing assistant are limited to $10.00 per day to a maximum stay of 120 days.
The maximum benefit payable for any convalescent hospital and nursing expense during the calendar year coincident with or next following the covered person's 65th birthday, shall be $500 (less any amounts paid during the three immediately preceding calendar years).

d. **Out-Of-Hospital Nursing Services**

Home nursing care is covered if:

(i) it starts while the Covered Person is insured under this Extended Health Care Benefit; and

(ii) it represents Acute, Convalescent or Palliative care.

No benefits will be paid for home nursing care for Medically Diagnosed Conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered Chronic Care. Care that is primarily chronic, custodial, or in the nature of physical maintenance, including but not limited to personal hygiene training or homemaking duties is not covered care under this Policy.

The maximum benefit payable for any person is $10,000 in any 3 consecutive years.

To establish the amount of coverage available under this provision before home nursing begins, the Employee must apply for a pre-determination of benefits.

**Pre-determination of Home Nursing Care Benefits**

A pre-determination of benefits is an assessment provided by Co-operators Life that identifies:

- the type of nurse that will be covered;
- the number of hours to be covered per day or week; and
- the estimated duration of coverage.

To receive a pre-determination of benefits, the Employee must submit a letter from the attending Physician containing:

- a description of the Covered Person’s current Medically Diagnosed Condition and prognosis;
- a list of the required nursing services and their frequency;
- an indication of the level of skill required to perform the required services, meaning those of a graduate registered nurse, licensed practical nurse, registered nursing assistant, certified nursing assistant or other practitioner;
- the number of hours of care required per day or week; and
- an estimate of the length of time care will be required.

Once all of the required information has been received and the claim has been assessed, Co-operators Life will then advise the Employee of the coverage that will be provided in accordance with this Provision. Co-operators Life reserves the right to request additional information at the time of claim and in relation to an ongoing claim.
These benefits are supplemental to any services the Covered Person is entitled to under their provincial home care plan. The Covered Person should apply for benefits through their provincial home care plan before applying for benefits under this Policy.

**Home Nursing Care Benefit**
Co-operators Life covers home nursing care provided in Canada. Nursing care is care that:

(i) requires the skills and training of a professional nurse; and

(ii) is provided by a professional nurse who is not a member of the Covered Person’s family.

Coverage is limited to the minimum number of hours and level of skill needed to provide each essential nursing service. Applicable licensing restrictions will be recognised in determining the level of skill needed. A professional nurse is a graduate registered nurse, licensed practical nurse, registered nursing assistant, or certified nursing assistant.

**Home Nursing Limitation**
No benefits will be paid for; companionship, counselling services, supportive care (bathing, dressing, feeding), child-care duties or house-keeping duties, or for nursing care for Medically Diagnosed Conditions where significant improvement or deterioration is unlikely within the next 12 months. This is considered Chronic Care.

e. **Physician's Expenses**

Charges by a general practitioner or specialist in excess of the amount allowed under the basic medical plan provided the payment of these charges is not prohibited by provincial legislation.

Where a physician has opted out the basic provincial medical plan, only those expenses in excess of what would have been allowed by the basic medical plan will be covered.

f. **Practitioners**

Charges for the services of the following practitioners, when treating sickness or injury, are covered to the maximum benefit of $750 per person per calendar year for each grouping of service:

- Osteopath/Chiropractor/Podiatrist
- Speech Therapist/Audiologist
- Naturopath/Acupuncturist
- Nutritionist/Dietician
- Naturopath/Acupuncturist
- Psychologist/Social Worker/Licensed Councillor

Services of physiotherapists, psychologists, speech therapists or massage therapists must be prescribed by a physician. The practitioner must be duly qualified, registered, and practicing within the scope of the appropriate license. The charges include x-ray examination when necessary.

Charges in excess of the amount allowed under the government health insurance plan, provided the payment of these charges is not prohibited by provincial legislation.
Where a physician has opted out of the government health insurance plan, only those expenses in excess of what would have been allowed by the government health insurance plan will be covered.

g. **Optometrist/Ophthalmologist Expenses**

Charges for eye examinations by an optometrist or ophthalmologist provided no part of the cost is covered by the government health insurance plan, limited to 1 examination per 2 calendar years and 1 per calendar year for dependents under 18.

h. **Ambulance Services**

Charges for ambulance service, including air ambulance. Where medically necessary, the fare of one attendant is also covered.

i. **Out-Patient Hospital Services**

Charges made by a hospital while the covered person is an out-patient for the following services and supplies:

- use of an examination room,
- drugs, obtainable only by prescription, dressings or casts and
- anaesthesia in connection with the performance of a surgical procedure.

No benefit will be payable with respect to charges made by a resident physician or intern of a hospital or for charges incurred while the covered person is entitled to similar benefits under the government health insurance plan.

j. **Drugs**

Co-operators Life will cover the expenses for the following drugs required to treat a Medically Diagnosed Condition:

(i) Drugs that require a Physician’s or Dentist’s prescription according to:

- the Food and Drugs Act, Canada; and
- provincial legislation in effect where the drug is dispensed.

NOTE: **contraceptive drugs are covered.**

(ii) drugs that must be injected, including vitamins, insulin and allergy extracts. Immunization vaccines are covered if they require a prescription by law.

(iii) extemporaneous preparations or compound mixtures must contain an active ingredient in a therapeutic concentration that is considered an eligible prescription drug under this provision. No benefits are payable for the following extemporaneous preparations or compound mixtures:

- drug compounds used primarily for cosmetic purposes;
- compounded medications which are the same as a pre-manufactured drug; or
• drug compounds which are not recognized as effective by the Therapeutic
  Products Directorate of the Health Protection Branch of Health Canada for
  the Medically Diagnosed Condition they are prescribed.

(iv) Drugs that do not require a prescription by law are covered if:
  • they are listed in the current Compendium of Pharmaceuticals and
    Specialties; and
  • they are prescribed by a Physician; and
  • they are categorized as life sustaining drugs, including but not limited to;
    anti-malarials, fibrinolytics, nitroglycerin, single entity iron salts, thyroid
    agents, or topical enzymatic debriding agents.

Government Drug Plans

Covered expenses for drugs eligible under any government drug Plan are limited
to any deductible and co-insurance amounts the Employee is required to pay for
himself and any eligible Dependents.

The following diabetic supplies are covered; syringes, lancets, pen needles and
blood test strips (excluding cotton swabs and rubbing alcohol). Diabetic
monitoring equipment is reimbursed under Therapeutic Equipment.

Generic Pay-Direct Drug Plan

Charges for prescription drug expenses will be limited to the lowest priced
generic equivalent.

Prescription Drugs Benefit Maximums

The maximum amount payable for products used to quit smoking that require a
prescription by law is $300 per Covered Person per lifetime.

Prescription Drugs Limitations

No prescription drug benefits will be paid for:

(i) any drug that does not have a drug identification number as defined
    by the Food and Drugs Act, Canada.
(ii) any drug prescribed for treatment of a medical condition that is not
    an approved indication by the manufacturer.
(iii) proprietary or patent medicines registered under the Food and Drugs
    Act, Canada.
(iv) any single purchase of a drug that would not reasonably be
    consumed or used within 30 days (for initial purchase) or 90 days
    (for refills).
(v) charges for any prescription drugs beyond the maximum dosage for a Covered Person’s course of treatment.

(vi) drugs dispensed by a Physician, Dentist or clinic or by a non-approved Hospital pharmacy.

(vii) drugs dispensed during treatment as an in-patient or an out-patient in an Approved Hospital.

(viii) drugs that are considered cosmetic, such as topical minoxidil for hair loss or sunscreens, whether or not prescribed for a medical reason.

(ix) fees for the administration of any injectable drugs, including but not limited to serums, vaccines, vitamins, insulin, and allergy extracts.

(x) drugs for the treatment of infertility, oral allergy serums, anti-obesity treatments, health foods, vitamins (unless injected).

(xi) drugs which would have been payable by the provincial plan if proper application had been made.

(xii) drugs prescribed for the treatment of erectile dysfunction, whether or not prescribed for a medical reason.

k. **Diabetic Supplies**

The following diabetic supplies are covered:

(i) insulin delivery pens.
(ii) insulin infusion sets and infusion pump supplies
(iii) syringes.
(iv) pen needles.
(v) lancets.
(vi) blood test strips.

Other diabetic monitoring and administration equipment is reimbursed under therapeutic equipment.

l. **Medical Services and Supplies**

When ordered by a physician in connection with the treatment of a covered person, the charges for the provision of anaesthesia, oxygen, blood and blood products. This will also include x-ray examinations where not covered by the government health insurance plan.

The initial charges for the following medical equipment required as a result of a medically diagnosed condition:

(i) Crutches, casts, trusses, walkers and canes.
(ii) Compression garments to treat burns.
(iii) Graduated compression hose, to a maximum of 2 pair per year.
(iv) Food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.

(v) Splints, including shoes attached to a splint. Intra-oral splints are not covered.

(vi) Orthopedic braces. Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not considered a covered extended health care expense.

m. Equipment

Orthopedic Shoes and Foot Orthotics
Coverage is provided for Orthopedic Shoes and custom made Foot Orthotics that are required as a result of a Medically Diagnosed Condition. Coverage is also provided for modifications to orthopedic shoes. The maximum amount payable per Covered Person is $300 in a 24 consecutive month period.

In order to be eligible for reimbursement of expenses the Orthopedic Shoes and/or Foot Orthotics must be:

- Prescribed by a Physician or foot Specialist (eg. podiatrist or chiropodist) and
- Fabricated and dispensed by an orthotist, pedorthist, podiatrist or chiropodist.

For each claim or predetermination, the Covered Person is required to supply Co-operators Life with the following:

- A detailed prescription (referral) from the prescribing Physician or foot Specialist
- A diagnosis of the condition, the biomechanical evaluation, gait analysis, description of the casting technique and the original receipt from the recognized provider.

Wheelchairs and Hospital Beds
Charges for the rental of, or at the insurance company’s option, the purchase of (if the company determines that the cost of purchase is less than the anticipated total cost of rental): a manual wheelchair, a standard hospital bed (excluding electric hospital beds). Where the insurance company deems it necessary, a motorized wheelchair may be substituted.

These charges will only be allowable if approved and prescribed by a physician and if they are required as the result of a bodily injury or sickness which occurred while covered under this plan text or a previous policy or plan text which was replaced by this plan text.
Therapeutic Equipment
Charges for the rental of, or at the insurance company’s option, purchase of the following therapeutic equipment, provided the equipment is approved and prescribed by a licensed physician and required due to a proven medical condition:

- diabetic administration equipment (insulin infusion pumps)
  (subject to a $500 lifetime maximum)
- transcutaneous nerve stimulator
- cervical collar
- aerosol equipment
- mist tents and nebulizers (excluding humidifiers and vaporizers)
- traction apparatus
- mozes detector

Coverage for any therapeutic equipment will be subject to 100% co-coverage and the lifetime maximum for any covered person will be $1,000 for any one or like piece of therapeutic equipment.

CPAP (continuous positive airway pressure) machines shall be covered subject to 100% co-coverage and a maximum of $1,500 per 60 months.

Prosthetic Equipment
Charges for the initial placement of artificial limbs, artificial eyes and mastectomy forms including two surgical bras in any one calendar year.

Charges for the subsequent replacement of artificial limbs and eyes where a physical change in the covered person necessitates the replacement, mastectomy forms once every 60 months where medically necessary.

Charges for prosthetic socks are covered to a maximum of 5 pair per year.

n. Accidental Dental Work
Charges for dental work performed by a dentist due to damage to natural teeth where the damage was caused by an injury, occasioned solely through violent, external and accidental means. This treatment must be performed within one (1) year of the date of the injury and must be the least expensive that will provide a professionally adequate treatment. The charges incurred will not exceed the current Dental Association Fee Guide for general practitioners in the covered person’s province or territory of residence.

o. Laboratory Expenses
Coverage is provided for diagnostic laboratory and x-ray expenses when coverage is not available under the Covered Person’s Government Health Insurance Plan; services must be received in the Covered Person’s province of residence and performed by a properly licensed lab technician. No benefits will be payable for services provided by a Physician or Specialist in the course of the private practice of medicine or received in a hospital or pharmacy.
Extended Health Care

p. **Hearing Aids**

Charges for the cost of, repair (excluding batteries or routine maintenance of) and installation of a hearing aid(s) purchased on the written recommendation of an audiologist, subject to a maximum benefit of $1,000 per 5 years.

q. **Ostomy Supplies**

Charges for essential ostomy supplies including irrigating sets, bags, deodorants, pads, adhesives, or skin creams.

r. **Northern Medical Transportation**

The Insurance Company will reimburse any Covered Person the amount of the deductible applicable to the government health insurance plan to a maximum of $125 for one-way travel or $250 for two-way travel.

s. **Vision Care**

The charges for the purchase of lenses, frames, or contact lenses when prescribed by a licensed optometrist or ophthalmologist will be covered. This coverage is not subject to the cash deductible or any co-coverage provision.

The following limitations and exclusions shall apply:

The maximum reimbursement shall be $350 in any 24 consecutive months per adult and $350 in any 12 consecutive months per dependent child. The "date dispensed" is used to determine payment of this benefit.
The maximum benefit payable to each covered person is indicated in the schedule of benefits. There is no coverage for any service or supply which does not provide for the correction of one's vision except when eyeglasses or contact lenses are prescribed by a licensed optometrist or ophthalmologist following eye surgery.

t. Laser Eye Surgery

Charges to a maximum of $1,500 per lifetime per covered person.

u. Hairpieces

Charges for the purchase of a hairpiece following chemotherapy or surgery where the head was shaved, limited to $200 per covered person per lifetime.

Limitation and Exclusions

This plan does not cover charges incurred for, caused by or contributed to by:

- medical examination for the use of a third party;
- obtaining further medical information regarding claims for covered expenses, or any expenses incurred for the completion of claim forms;
- a physician or other health practitioner for travel, broken appointments or communication costs;
- charges which are not permitted by law/legislation for the insurance company to reimburse. Any changes to provincial or territorial legislation or the government health insurance plan will not automatically result in a change of coverage provided under this plan text;
- cosmetic surgery, services or treatment which are not necessary for treatment of a sickness or injury;
- the failure of any covered person to make claim for and receive benefits within the time and in the manner prescribed under or pursuant to the government health insurance plan to which they are entitled. If a covered person is not a member of a government health insurance plan by reason of having “opted-out”, or for any other reason is not a member of a government health insurance plan the employee will be deemed, for the purposes of this plan text, to be a member of the government health insurance plan;
- extra charges which may result due to the physician opting-out of the government health insurance plan;
- bodily injury resulting directly or indirectly from war or act of war, insurrection, riot, hostilities of any kind, or when a covered person is a member of the armed forces of any government;
- any criminal offense;
- suicide or attempted suicide;
Extended Health Care

- charges in excess of what is reasonable & customary in your province or territory of residence;

- expenses for which no charge would ordinarily be made if there were no coverage;

- the renovation or alteration in any physical way to a covered person’s residence, vehicles, or place of business, including the filtration or purification, whether mechanical or electronic, of air, water or other environmental factors;

- the repair or alteration of any prosthetic device incurred after the initial placement and fitting or charges incurred due to the replacement of any prosthetic device unless the replacement is due to a change in the covered person’s physical condition;

- anti-obesity treatment including drugs, proteins and dietary or food supplements whether or not prescribed for a medical reason;

- private or semi-private room charges in an acute care hospital where the type of care is primarily custodial care or while awaiting admission to a custodial care facility;

- charges for any method of contraception other than contraceptive drugs;

- any benefit otherwise payable under this plan text will be reduced by any amount the covered person received or is eligible to receive from:
  - the government health insurance plan,
  - Workers’ Compensation Act,
  - any government hospital, medical, dental or health care plan, whether payable or not.

Where payment is available under a charitable organization or any other plan, it will be made as per the co-ordination of benefits provision.

- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society;

- charges not specified in the list of covered eligible medical expenses.

Third Party Liability

If you or your dependent are eligible for reimbursement of medical expenses for which a third party is, or may be, legally liable, expenses will not be reimbursed under this plan text unless you or your dependent agree to repay The Co-operators the full amount of the expenses reimbursed from the third party.

Co-ordination of Benefits

If you have coverage under more than one plan, benefits will be co-ordinated so that the amount payable from all plans will not exceed 100% of the actual allowable expenses.
Late Entrant Limitation

If you apply for extended health care coverage more than one month after you or your dependents become eligible, coverage will not be provided until health evidence has been approved by The Co-operators.

Survivor Benefit

In the event of your death, your dependents will continue to receive these benefits, without payment of deposits for a period of 1 year, provided the dependent does not become eligible for benefits under any other group benefits plan as either an employee or dependent and the dependent remains eligible as defined.

Emergency Medical Travel Assistance Service

Be sure to take your Emergency Medical Travel Assistance ID card with you whenever you travel outside Canada. It lists important telephone numbers that you may need. Please contact your employer/plan administrator if you misplace your card.

If a medical emergency arises while travelling, you must notify the emergency medical travel assistance service within 48 hours of admission to a hospital. If you fail to do so, benefits will be reduced.

When using the service, you’ll be asked to provide your name, location, the name of the company you work for, your group policy number and account number and the specific details regarding your emergency.

When coverage has been confirmed, a qualified representative will give you advice about doctors and hospitals, confirm coverage to doctors, maintain contact with treating physicians, make advance payment if required and supply details to your family or employer.

Travel assistance also provides additional support to travellers including legal referrals, referrals to English-speaking doctors, consulate and embassy references and telephone assistance with interpreters.

Some of the above services may be limited or suspended in the event of circumstances such as war, insurrection, foreign hostility, riot, rebellion, military uprising, labour disturbances, martial law, strikes, nuclear accidents, or acts of God.

Extended Health Care conversion privilege

If your employment terminates or if you have over-age dependent children who are no longer eligible under the plan, you may convert this coverage to an individual plan without providing health evidence. The individual plan will not be identical to the group plan. You must apply for conversion within 60 days of the end of coverage under the Extended Health Care Plan. Please contact your employer/plan administrator for more details regarding conversion.

Submitting a Claim

The time limit within which an extended health insurance claim must be made is 1 year from the date of incurral of the expense. If this coverage terminates, all claims must be submitted within 90 days from the date of termination.
Termination Age

Your extended health care benefits terminate at age 70.
DENTAL CARE

Check with your EMPLOYER to find out if DENTAL coverage is offered by the NEBS employer for whom you work. If your employer offers this coverage, you have the choice whether to participate.

This benefit is designed to promote good dental care at a reasonable and level cost.

Deductible

The amount of $25 for singles and $50 for families will be deducted from the covered charges incurred in any one calendar year.

Coverage Maximums

Benefits will not exceed the current Territorial or Provincial Dental Association Schedule of fees for General Practitioners or Specialists in the province or territory where the service was rendered.

The maximum reimbursement per calendar year will not exceed the amounts per person indicated in the following schedule:

Plan A - Basic services:  Combined maximum of $2,000 per covered person
Plan B - Major restorative services:  $3,500 during the lifetime of a dependent child.
Plan C - Orthodontic services:

Alternate Benefit

Where there are two or more courses of treatment available to adequately correct a dental condition, reimbursement may be based on the cost of the least expensive treatment. (The alternate benefit is in no way an attempt to change a treatment plan. The choice of the treatment is a matter for agreement solely between the patient and the dentist).

Pre-determination

Dental treatment likely to exceed $400 should be submitted to The Co-operators for prior approval. This procedure will identify the cost you may be responsible for and will provide you with an opportunity to seek an alternate course of treatment if necessary.

Plan A - Basic Services

The plan will cover 100% of the following eligible charges:

- Routine examinations, cleaning of the teeth (up to and including 2 time units of polishing) and two cavity revealing x-rays (bite wings) are covered twice in a 12 consecutive month period. Fluoride application to the teeth of children (up to the age of 21) is covered twice in a 12 consecutive month period. Fluoride application for adults is covered once in a 12 consecutive month period. Specific oral examinations and emergency examinations are not unlimited. If these services are used within the same 6 month period as a routine or an initial examination, the Dentist may be required to submit an explanatory note regarding the repeating of the examination.
Dental Care

- A complete dental examination is covered once only with any one particular dentist, and only once in a 36 consecutive month period if the dentist is changed, provided the plan has not paid for any other examination during the past 6 months.

- Full mouth, or complete series X-rays covered only once in a 24 consecutive month period.

- Tooth extractions.

- Minor surgical procedures, simple extractions and post-surgical care. Complicated extractions including impacted and residual roots are also covered. Reasonable and customary expenses for anaesthesia in conjunction with covered surgical procedures are covered. Any charges for facility fees or other related expenses are not covered.

- Fillings, both silver amalgam and tooth-coloured plastic resins, for restoring the natural tooth surfaces.

- Treatment for the relief of dental pain.

- Simple space maintainers for keeping the space of a lost baby tooth open until the permanent tooth comes in. A similar appliance for the assistance of breaking habits, such as thumb-sucking, is also covered.

- Denture repairs, resetting and relining of removable denture teeth, once every 36 consecutive months.

- Root canal therapy (endodontics).

- Treatment of the gums (periodontics).

- Stainless steel crowns for the repair of children’s teeth.

- Interproximal discing.

- Laboratory expenses.

- Oral hygiene instruction once in a 12 consecutive month period.

Plan A - Exclusions and Limitations

- Full mouth series of radiographs and panoramic films are considered the same for the purpose of this plan text. Either, but not both, will be allowed once in a 24 consecutive month period.

- The insurance company reserves the right to alter the benefits payable where multiple restorative services are performed at a single appointment in one quadrant of the mouth. In such a case, where the time value for a service is decreased, it may be assumed that the relative value units (RVU) for the service or services will also be reduced.
Dental Care

- Pit and fissure sealants are covered for dependent children under 14 years of age.

- The insurance company reserves the right to request radiographs for the purpose of establishing benefits for multiple extractions to third molars. The insurance company also reserves the right to request radiographs in order to establish benefits for multiple composite restorations in upper or lower anterior teeth or where numerous restorations are involved.

- Canal enlargement will not be covered as a separate procedure.

- Desensitization of teeth and pulp mummification will not be covered as a separate procedure.

- Caries and pain control procedures will only be covered when performed on a day separate from any other restorative procedure.

- Scaling, root planing and occlusal equilibration are limited to 8 time units for each service per calendar year.

- Periodontal surgery is limited to 4 sites per calendar year with one surgical procedure per site. Reasonable and Customary expenses are payable for anaesthetic when required in conjunction with covered periodontal or oral surgery. Any charges for facility fees or other related expenses are not covered. All requests for periodontal appliance coverage must be referred to the Insurance Company's dental consultant before being approved.

- Opening through a crown is not payable in conjunction with endodontic therapy.

**Plan B - Major Restorative Services**

The plan will cover 60% of the following eligible charges.

- The initial provision of crowns or onlays if the tooth is broken down due to traumatic injury, fracture of the tooth or cusps, or where there have been very large areas of filling combined with decay which prevent the use of more traditional filling materials such as silver amalgam and plastics. Stainless steel crowns for an adult must fulfill the same criteria as a regular crown to be a covered benefit.

- Replacement of existing crowns or onlays after a period of 5 years since placement of the restoration and if the restoration is no longer serviceable.

- Initial installation of full dentures, tooth implants, partial removable dentures, or fixed bridgework, if required to replace one or more natural teeth, at least one of which has been extracted after the effective date of the covered individual’s coverage under this plan text.

- Replacement of existing full dentures, partial removable dentures or fixed bridgework after a period of 5 years since the initial placement and if the appliance is no longer serviceable. Appliances will be replaced with like (similar type) appliances.

- Addition of teeth to existing dentures or fixed bridgework, if required to replace the natural tooth/teeth extracted after the effective date of the covered individual’s coverage under this plan text.
• Adjustments to a new partial or complete denture would be covered after the denture has been worn for at least 3 months.

• All veneers, composite, porcelain whether lab processed or not.

• Repairs to covered crowns and bridgework including removal and recementation.

• Posts, cores and retentive pins related to covered crowns, implants and bridgework.

**Plan B - Exclusions and Limitations**

• All veneers, composite, porcelain requests whether lab processed or not, must be referred to the dental consultant for approval.

• Crowns needed due to wear (attrition) and cosmetic reasons are not covered.

• Denture cleaning and polishing is not covered.

• No extra charge over that for the crown itself is payable for a crown made to fit an existing partial denture clasp. The extra lab charge, if any, is payable.

• Services or supplies for equilibration of dentures will not be covered.

• Services for precision attachments, oral rehabilitation, personalization or characterization or any charge for both a permanent and temporary crown or prosthesis in excess of the eligible charge for the permanent crown or prosthesis alone will not be covered.

• No benefit will be payable for the replacement of crowns, bridges or dentures which are less than 5 years old and unserviceable. In the case of dentures, no benefits are payable for appliances which are mislaid, lost or stolen.

• No benefit will be payable for other than metal-only (as opposed to porcelain or acrylic on metal) crowns or pontics, posterior to the second bicuspid tooth.

• No benefit will be payable for the initial installation (or addition) of prosthetic devices unless such installation (or addition) is required primarily due to teeth that were lost, extracted or fractured (so that removal was necessitated) after the effective date for such prosthetic devices under this plan text.

• All expenses covered under this section must be pre-determined.

**Plan C - Orthodontic Services**

The plan will cover 50% of the following eligible charges.

• Charges incurred for treatment, services and appliances used in the correction of malocclusion caused by dental irregularities, for dependent children under the age of 19.
Plan C - Exclusions and Limitations

- For each course of orthodontic treatment, a treatment plan is required. If the orthodontic treatment is terminated before completion, the Plan Sponsor’s obligation to pay benefits will cease at such termination. Should the treatment be resumed, benefit payments for these services shall be resumed to the extent specified in the original treatment plan.

- Expenses incurred for any procedure which commenced before the date the covered person became covered under this benefit are not covered. However, if this plan text replaces coverage for orthodontic services with another company, the insurance company may, at its discretion and subject to the submission of a treatment plan, assume responsibility for charges incurred in respect of the completion of a course of orthodontic treatment which was begun prior to the effective date of coverage.

- The initial payment for orthodontic services claimed will be the lesser of:
  - the initial deposit required by the practitioner, or
  - one-third of the covered expense for the entire treatment plan.

  The balance of the covered expense, after the deduction of the initial payment, will be paid as service is rendered. A claim form is to be submitted after each stage of the treatment plan has been completed.

  Note: The above payments will be subject to any applicable deductible, and paid at the specified percentage.

- Lost or stolen orthodontic appliances will not be replaced.

Late Entrant Limitation

If you apply for dental coverage more than one month after you or your dependents become eligible, the maximum benefit for you and your eligible dependents will be $250 per person during the first 12 months of dental coverage.

Survivor Benefit

In the event of your death, your dependents will continue to receive these benefits, without payment of deposits for a period of 1 year, provided the dependent does not become eligible for benefits under any other group benefits plan as either an employee or dependent and the dependent remains eligible as defined.

Third Party Liability

If you or your dependent are eligible for reimbursement of dental expenses for which a third party is, or may be, legally liable, expenses will not be reimbursed under this plan text unless you or your dependent agree to repay The Co-operators the full amount of the expenses reimbursed from the third party.
Co-ordination of Benefits

If you have coverage under more than one plan, benefits will be co-ordinated so that the amount payable will not exceed 100% of the actual allowable expenses.

General Limitations and Exclusions

No amount shall be payable under this benefit for charges:

- incurred as a result of self inflicted injury.
- which are excluded under any general limitations for health insurance.
- incurred as a result of any dental disease, defect or injury arising out of or in the course of an covered individual’s employment, unless otherwise specifically stated in the policy schedule.
- for procedures, appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or vertical wear, or to restore occlusion or to treat, in any form, problems of the temporomandibular joint.
- for services which would not normally have been made but for the presence of this coverage or for which the employee or dependent is not legally obligated to pay, or for which dental care is provided or may be provided to a covered person without cost or at a nominal cost by public authorities, or under a government medical plan, or accidents or diseases covered by the Workers’ Compensation Act or any like statute.
- for dental treatment not approved by the Canadian Dental Association or which is experimental in nature.
- for dental care deemed to be cosmetic in nature, including bleaching of endodontically treated teeth, or with respect to congenital malformations or for the replacement of congenitally missing or supernumerary teeth.
- for services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting, or provoking an assault or criminal offence, or by a war or act of war (whether declared or not) insurrection or riot, or hostilities of any kind.
- for miscellaneous services such as for counselling or instruction, treatment planning, filling out of claim forms or predeterminations, consultations other than with specialists, travel, broken appointments or communication costs.
- for any dental examinations required by a third party.
- for services or fees which do not fulfil, within the criteria of dental practice in the province or territory in which the claimant resides, of usual and customary treatment or fees.
- Charges for anaesthesia unless in conjunction with oral or periodontal surgery.
• for or in connection with orthodontic treatments, including correction of malocclusion, unless such treatment is specifically included in the plan text.

• for bacteriological tests or smears unless submitted with a letter of expertise from the dentist explaining the treatment.

• for diagnostic casts unless required for orthodontic treatment.

Work in Progress
If specific dental treatments (as outlined in this section and which would normally be covered by your dental plan) commenced prior to termination of benefits (provided that there is no replacing dental coverage after termination) an extension of coverage for such "Work in Progress" will apply in accordance with the following:

  o Where an impression for a denture, bridge or crown was taken or the surgical component of an implant was inserted or root canal therapy was started prior to the termination of coverage, dental expenses in connection with these procedures incurred within 30 days of termination will be considered as incurred prior to termination.

  o Where orthodontic treatment has commenced and a treatment plan has been submitted in advance to the insurance company, dental expenses in connection with such treatment incurred within 90 days of termination will be considered as incurred prior to termination.

For the purposes of this provision, a dental charge or expense shall be deemed to have been incurred as of the date the procedure or service is performed.

In the case of root canal therapy, crowns, implants, dentures or bridgework, which may require multiple appointments, the date the expense is incurred will be the date the service is finally completed. For dentures or bridgework, this date will be the date the prosthetic device is installed. For crowns, this will be the date the permanent crown is installed and for root canal therapy, this will be the date the canal is closed.

Dental Care conversion privilege
If your employment terminates or if you have over-age dependent children who are no longer eligible under the plan, you may convert this coverage to an individual plan without providing health evidence. The individual plan will not be identical to the group plan. You must apply for conversion within 60 days of the end of coverage under the Dental Care Plan. Please contact your employer/plan administrator for more details regarding conversion.

Submitting a Claim
The time limit within which a dental claim must be made is 1 year from the date of incurral of the expense. If this coverage terminates, all claims must be submitted within 90 days from the date of termination.

Termination Age
Your dental care benefit terminates at age 70.
OPTIONAL GROUP LIFE INSURANCE

In addition to your basic group life insurance, you may wish to apply for an additional amount of group life insurance for you, your spouse and your dependent parent by completing the application form provided by The Co-operators. If your applications are approved, coverage will take effect the first day of the next month. The Co-operators will be responsible for any medical fees incurred for information required in order to proceed with your application.

The amount of insurance shown below is available for your selection.

<table>
<thead>
<tr>
<th>Each employee &amp;/or eligible spouse</th>
<th>Units of $10,000 to a maximum of $200,000.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each eligible dependent parent</td>
<td>$5,000</td>
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</tbody>
</table>

**Total Disability Waiver of Premium**

If you are totally disabled and the premiums for your basic life insurance coverage are being waived, then premiums for the optional life insurance will also be waived.

**Exclusions**

This benefit is not payable where the cause of death is suicide occurring within two (2) years from the date your coverage became effective.

**Termination Age**

Optional group life insurance benefit terminates at attainment of the covered person’s 70th birthday.
Northern Employee Benefits Services Privacy Statement

Northern Employee Benefits Services (NEBS) is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

When you complete your enrolment form for the (NEBS) Group Insurance and Health Benefits Plan you are required to sign and authorize the Northern Employee Benefits Services and their insurance underwriters to release and exchange the personal information you have provided about you, your spouse or dependents. This information is used for the purposes of determining eligibility and providing administrative services and benefits to you.
Cooperators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

When you apply for coverage or benefits, Co-operators must gather personal information about you, your spouse or dependents.

We use this personal information for the purposes of providing group benefit plan administration services and insurance products to you.

Maintaining the security of your personal information is a top priority. Only authorized personnel have access to your information, and our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security is emphasized in our Code of Ethics and extends to the contracts and agreements that we sign with external suppliers and service providers.

Co-operators does not collect, use or disclose your personal information without your consent, except where authorized by law.

Co-operators may require your medical information to administer the group benefits plan. We do not share your medical information without your express consent.

You have the right to access your personal information. Send us your requests in writing and ask us to correct inaccurate information. The medical information not collected directly from you may only be released directly through your physician. For more information on how to obtain access to your file, you may write directly to:

Co-operators Life Insurance Company
Attention: Group Insurance Department - Privacy
1920 College Avenue
Regina, Saskatchewan
S4P 1C4
E: privacy@cooperators.ca