Northern Employee Benefits Services
Group Number G. 799

NORTHERN EMPLOYEE BENEFITS SERVICES | ᐅᑭᐅᖅᑕᖅᑐᒥᑯᓇᓗᑦᑯᑯ ᐃᑲᔪᓯᐊᖅᑕᕈᑎᒋᕙᖅᑕᖕᒋᓐᓄᑦ ᐱᔾᔪᓯᕋᖅᑏᑦ

the co-operators
A Better Place For You®

Your Group Benefits Plan

Northern Employee Benefits Services
Group Number G. 799
Effective: October 1, 2019
Issued: October 24, 2019

For more information visit www.cooperators.ca/group/*groupbenefits*

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INTRODUCTION

WELCOME TO YOUR GROUP BENEFITS PLAN

We are pleased to provide you with a comprehensive package of group benefits provided by your employer through Co-operators Life Insurance Company. Your group benefit plan provides valuable security in the event of sickness or death. This booklet outlines your benefit plan as of the date shown on the cover.

This booklet outlines the general coverage information for your group benefit plan. We encourage you to read and understand the benefits that your employer is providing for you and save this booklet in a safe place. If you have any questions, please contact your employer or the person who administers your group benefit plan.

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

- Basic Life Insurance
- Dependent Life Insurance
- Long Term Disability Benefits

Not all employers participating in the Northern Employee Benefits Services (NEBS) Group Benefits Program have the same optional coverage. The optional plans available include:

- Short Term Disability Benefits
- Extended Health Care Benefits
- Dental Care Benefits
- Elected Councillors and Appointed Board Members Insurance

For employers who choose coverage for Elected Councillors and/or Appointed Board Members, the following coverage is available:

- Basic Life Insurance

Your employer and/or plan administrator is responsible for making sure that all employees are covered for the benefits they are entitled to by submitting all required premiums/deposit payments, reporting all new enrolments, terminations, any salary or benefit changes and by keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your employer/plan administrator with the necessary information to perform such duties.

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

The master Policy and Plan Text G. 799 issued by the 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 Plan Text, the terms and conditions of the Policy and Plan Text will prevail.

Extended Health Care Plan
The Plan Sponsor funds a portion of the Extended Health Care Plan. This means that the Plan Sponsor has the sole legal and financial liability for benefits and funds the claims up to the stop loss insurance level agreed to by the Plan Sponsor. Co-operators Life is only the administrator of this plan up to the stop loss insurance level. Amounts under the stop-loss insurance level are not insured by the Co-operators Life Insurance Company. It has no liability whatsoever to plan members including any liability for benefits provided under the stop loss level.

Dental Care Plan

The Plan Sponsor funds the Dental Plan. This means that the Plan Sponsor has the sole legal and financial liability for this benefit and funds the claims. Co-operators Life is only the administrator of the Dental Care Plan. The Dental Plan is not insured by the Co-operators Life Insurance Company. It has no liability whatsoever to plan members including any liability for benefits provided under the Plan.

Your employer and/or plan administrator reserves the right to amend, modify, qualify, reduce, suspend or terminate any of the benefits provided under the master group policy and/or plan text covering employees and if applicable former employees, including retirees, at any time, including after an employee's retirement.

SCHEDULE OF BENEFITS

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

Classes of Employees:
- Employees
- Elected Councillors
- Appointed Board Members

Minimum number of hours per week:
Actively working on a full-time basis for at least 20 hours per week.

BASIC LIFE INSURANCE
Insurance provided by Co-operators Life Insurance Company

Eligible Class:	**Employees**
OPTION 1	
Benefit Formula:	300% of annual Salary, rounded to the next highest $1,000 if not already a multiple thereof.
Amount of Insurance:	The amount calculated using the benefit formula. The maximum amount of insurance is: Non-Evidence Maximum: $300,000 Health Evidence Maximum: $300,000 At age 65, the amount of insurance reduces by 50% to a maximum of $150,000. At age 70, the amount of insurance further reduces by 50% to a maximum of $75,000.
Living Assistance Benefit:	50% of the Amount of Insurance to a maximum amount of $50,000. Terminates at age 65.
Termination age:	Employee's 75th birthday
Life waiver of premium waiting period:	Is equal to the long term disability Elimination Period. Premiums will be waived retroactively to the initial date of Total Disability. The definition of Total Disability for the Basic Life Waiver matches the definition of Total Disability for the Long Term Disability Benefit as defined in the Policy. Waiver of premium terminates at age 65.

OPTION 2

Benefit Formula: 150% of annual Salary, rounded to the next highest $1,000 if not already a multiple thereof.

Amount of Insurance: The amount calculated using the benefit formula. The maximum amount of insurance is:

Non-Evidence Maximum: $150,000
Health Evidence Maximum: $150,000

At age 65, the amount of insurance reduces by 50% to a maximum of $75,000.

At age 70, the amount of insurance further reduces by 50% to a maximum of $37,500.

Living Assistance Benefit: 50% of the Amount of Insurance to a maximum amount of $50,000. Terminates at age 65.

Termination age: Employee's 75th birthday

Life waiver of premium waiting period: Is equal to the long term disability Elimination Period. Premiums will be waived retroactively to the initial date of Total Disability. The definition of Total Disability for the Basic Life Waiver matches the definition of Total Disability for the Long Term Disability Benefit as defined in the Policy. Waiver of premium terminates at age 65.

Eligible Class: **Elected Councillors**
Appointed Board Members
(if your employer has chosen this option)

Benefit Formula: Flat $100,000 per Employee.

Amount of Insurance: The amount calculated using the benefit formula. The maximum amount of insurance is:

Non-Evidence Maximum: $100,000
Health Evidence Maximum: $100,000

At age 65, the amount of insurance reduces by 50% to a maximum of $50,000.

At age 70, the amount of insurance further reduces by 50% to a maximum of $25,000.

Living Assistance Benefit: 50% of the Amount of Insurance to a maximum amount of $50,000. Terminates at age 65.

Termination age:	Employee's 75th birthday
Total Disability Life Waiver:	not applicable

DEPENDENT LIFE INSURANCE
Insurance provided by Co-operators Life Insurance Company

Eligible Class:	**Employees**
Amount of Insurance:	$10,000 Spouse amount $5,000 Child amount (from Birth)
Termination age:	Employee's 70th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

OPTIONAL LIFE INSURANCE
Insurance provided by Co-operators Life Insurance Company

Eligible Class:	**Employees**
Amount of Insurance:	An Employee and/or Spouse may select any amount of insurance from a minimum of $10,000 to a maximum of $200,000 in units of $10,000. A Dependent Parent may select an amount of insurance of a flat $5,000.
Termination age:	70th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

SHORT TERM DISABILITY BENEFITS
(if your employer has chosen this option)

Insurance provided by Co-operators Life Insurance Company

Eligible Class:	**Employees**
OPTION 1	
Benefit Formula:	60% of weekly Salary, rounded to the next highest $1 if not already a multiple thereof.
Weekly Benefit:	The amount calculated using the benefit formula or the amount calculated using the formula for the All Source Maximum, whichever is less.
Weekly Benefit Maximum:	$1,535
All Source Maximum:	85% of pre-disability Net Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	- for Injury .....0 consecutive Days
	- for Sickness .....7 consecutive Days
First day hospitalization:	No
Benefit Period:	17 weeks from the Disability Date
Recurrent Total Disability:	4 weeks
Short Term Disability Week:	5 days
Tax Status:	Non-taxable
CPP/QPP Offset:	Primary
Termination age:	Employee's 65th birthday
Waiver of premium waiting period:	is equal to the Short Term Disability Elimination Period. Premiums will be waived retroactively to the initial date of Total Disability. Waiver of premium terminates at age 65.

OPTION 2

Benefit Formula:	70% of weekly Salary, rounded to the next highest $1 if not already a multiple thereof.
Weekly Benefit:	The amount calculated using the benefit formula or the amount calculated using the formula for the All Source Maximum, whichever is less.
Weekly Benefit Maximum:	$1,535
All Source Maximum:	85% of pre-disability gross Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	- for Injury .....0 consecutive Days - for Sickness .....7 consecutive Days
First day hospitalization:	No
Benefit Period:	17 weeks from the Disability Date
Recurrent Total Disability:	4 weeks
Short Term Disability Week:	5 days
Tax Status:	Taxable
CPP/QPP Offset:	Primary
Termination age:	Employee's 65th birthday
Waiver of premium waiting period:	is equal to the Short Term Disability Elimination Period. Premiums will be waived retroactively to the initial date of Total Disability. Waiver of premium terminates at age 65.

LONG TERM DISABILITY BENEFITS

Insurance provided by Co-operators Life Insurance Company

Eligible Class:	**Employees**

OPTION 1

Benefit Formula:	60% of monthly Salary, rounded to the next highest $1 if not already a multiple thereof.
Monthly Benefit:	The amount calculated using the benefit formula. The maximum Monthly Benefit is the lesser of $6,600 or the amount calculated using the formula for the All Source Maximum. Non-Evidence Maximum: $6,600 Health Evidence Maximum: $6,600
All Source Maximum:	85% of pre-disability Net Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	- for Injury ..... 119 consecutive Days - for Sickness ..... 119 consecutive Days
Own Occupation Period:	The Elimination Period and the next 24 months thereafter must be Totally Disabled from any and all occupations.
Maximum Benefit Duration:	to age 65
Recurrent Total Disability:	6 months
Tax Status:	Non-taxable
CPP/QPP Offset:	Primary
Termination age:	Employee's 65th birthday
Waiver of premium waiting period:	is equal to the Long Term Disability Elimination Period. Premiums will be waived retroactively to the initial date of Total Disability. Waiver of premium terminates at age 65.

OPTION 2

Benefit Formula:	70% of monthly Salary, rounded to the next highest $1 if not already a multiple thereof.
Monthly Benefit:	The amount calculated using the benefit formula. The maximum Monthly Benefit is the lesser of $6,600 or the amount calculated using the formula for the All Source Maximum. Non-Evidence Maximum: $6,600 Health Evidence Maximum: $6,600
All Source Maximum:	85% of pre-disability gross Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	- for Injury ..... 119 consecutive Days - for Sickness ..... 119 consecutive Days
Own Occupation Period:	The Elimination Period and the next 24 months thereafter must be Totally Disabled from any and all occupations.
Maximum Benefit Duration:	to age 65
Recurrent Total Disability:	6 months
Tax Status:	Taxable
CPP/QPP Offset:	Primary
Termination age:	Employee's 65th birthday
Waiver of premium waiting period:	is equal to the Long Term Disability Elimination Period. Premiums will be waived retroactively to the initial date of Total Disability. Waiver of premium terminates at age 65.

EXTENDED HEALTH CARE BENEFITS
(if your employer has chosen this option)

Coverage administered by Co-operators Life Insurance Company

References to year means calendar year, references to months means consecutive months.

Eligible Class: **All Employees**

Deductible:

- for Hospital expenses per year.....$0
- for Emergency Out of Canada and Travel Benefits Plus per year.....$0
- for Prescription Drug expenses per year.....$0
- for Vision Care expenses per year.....$0
- for All Other Extended Health Care expenses per year:
  - ⇨ Employee $0
  - ⇨ Employee with Dependents.....$0

Premier Drug Plan:

- Pay-Direct Card Plan
- mandatory generic drug equivalent only (lowest cost interchangeable drug)
- Pharmacy dispensing fees exceeding the Reasonable and Customary amount per prescription are not covered

Co-coverage:

- for Hospital expenses.....100%
- for Emergency Out of Canada expenses and Travel Benefits Plus 100%
- for Vision Care expenses.....100%
- for Therapeutic Equipment.....100%
- for Prescription Drugs 100%
- for all other Extended Health Care expenses.....100%

Maximums per Covered Person:

- Emergency Out of Canada maximum per Injury or Sickness $1,000,000
- Extended Health Care calendar year maximum .....unlimited
- Travel Benefits Plus

Maximum Out of Country duration .....90 days

Extended Health Care Benefit Maximums:

- for hospital accommodation .....semi-private room
- *for Convalescent Hospital.....$20 per Day & 120 Days
- *for Out-of-Convalescent Hospital nursing expenses.....$10 per Day & 120 Days

*The maximum benefit payable for any Convalescent Hospital nursing expenses or Out-of-Convalescent Hospital expenses during the calendar year on or after the calendar year coincident with or next following the Covered Person's 65th birthday, shall be $500 less any amounts paid during the three (3) immediately preceding calendar years.

- for home nursing care ..... $10,000 per 3 consecutive years

- for paramedical practitioners:
  - ⇨ Acupuncturist/Naturopath ..... $750 per year
  - ⇨ Audiologist/Speech Therapist ..... $750 per year
  - ⇨ Chiropractor/Osteopath/Podiatrist ..... $750 per year
  - ⇨ Massage Therapist/Physiotherapist ..... $750 per year
  - ⇨ Nutritionist/Dietitian ..... $750 per year
  - ⇨ Psychologist/Social Worker/Licensed Counsellor ..... $750 per year

  X-rays are included in the maximums.

- for Eye Examinations:
  - ⇨ for Adults ..... one exam per 2 years
  - ⇨ for Dependent Children (under 18 years of age) ..... one exam per year

- for Vision Care Prescription eye-wear and Prescription safety glasses:
  - ⇨ for Adults ..... $350 per 24 months
  - ⇨ for Dependent Children (under 18 years of age) ..... $350 per 12 months
  - ⇨ the maximum includes one pair of eyeglasses or one pair of contact lenses following eye surgery

- for laser eye surgery ..... $1,500 per lifetime
- for Diabetic Supplies ..... unlimited
- for custom-made Orthopedic Shoes and custom-made Orthotics combined ..... $300 per 24 months
- for prescription anti-smoking aids ..... $300 per lifetime
- for anti-obesity drugs ..... no coverage
- for fertility drugs ..... no coverage
- for sexual dysfunction drugs ..... no coverage
- for hearing aids ..... $1,000 per 5 years
- for Therapeutic Equipment ..... $1,000 per piece of equipment per lifetime

  (transcutaneous nerve stimulator (TENS), cervical collar, aerosol equipment, mist tents and nebulizers (excluding humidifiers and vaporizers), traction apparatus, Enuresis alarm (formerly referred to as a mozes detector), apnea monitor for respiratory dysrhythmia, peak flow meter, aerochambers, chest percussors, drainage boards and sputum stands, tracheostoma tubes and suction pumps)

- for diabetic administration equipment (insulin infusion pumps) and diabetic blood glucose monitoring equipment (BGM machines) ..... $500 per lifetime
- for each prosthetic limb and each artificial eye ..... $25,000 per lifetime

- for prosthetic socks ..... 5 pair per year
- for hair pieces following surgery or treatment ..... $200 per lifetime
- for external breast prosthesis (mastectomy forms) ..... once per 5 years
- for surgical brassieres ..... 2 per year
- for graduated compression hose ..... 2 pair per year
- for breathing machines and equipment (such as IPPB/APAP/CPAP/BiPAP or other similar type of breathing machines or equipment that are medically necessary) ..... $1,500 per 60 months
- for Northern Medical Transportation:
  - for one-way travel $200
  - for two-way travel $400

Survivor Benefit for Dependents: ..... 1 year

Termination age for Out of Country benefits (including Travel Benefits Plus): .. Employee's 65th birthday
Termination age for all other EHC benefits: ..... Employee's 70th birthday

DENTAL CARE BENEFITS
(if your employer has chosen this option)

Coverage administered by Co-operators Life Insurance Company

References to year means calendar year unless otherwise indicated, references to months means consecutive months.

Eligible Class: **All Employees**

Calendar Year Deductible:

- Employee $25
- Employee with Dependents $50

Co-coverage Levels:

- Level 1 ..... *Basic Restorative Services* 100%
- Level 2 ..... *Endodontic & Periodontic Services* 100%
- Level 3 ..... *Major Restorative Services* 60%
- Level 4 ..... *Orthodontic Services* 50%

Dental Care Benefit Maximums:

- Level 1 ..... *Basic Restorative Services* $2,000
- Level 2 ..... *Endodontic & Periodontic Services* ..... combined
- Level 3 ..... *Major Restorative Services* ..... maximum per year
- Level 4 ..... *Orthodontic Services* ..... $3,500 lifetime

Dental Fee Guide for General Practitioners and Specialists: .....Current year

Other Dental Care Information:

- ⇨ Recall exams, 2 bitewing x-rays and cleaning, twice every 12 months.
- ⇨ Fluoride treatment for Children up to the age of 21 only, twice every 12 months.
- ⇨ Fluoride treatment for adults, once every 12 months.
- ⇨ Orthodontic Services for Dependent Children up to the age of 19.
- ⇨ Oral hygiene instruction is covered once per lifetime under Level 1.
- ⇨ Missing tooth limitation for Major dental services (dentures, bridges/implants).
- ⇨ Pit and Fissure Sealants for Dependent Children under age 14.
- ⇨ Periodontic scaling, root planing and occlusal adjustment and equilibration: maximum 8 time units for each service per year.

Survivor Benefit for Dependents:.....1 year

Termination age:.....Employee's 70th birthday

GENERAL INFORMATION

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

- actively working on a regular permanent basis, for the minimum number of hours per week as indicated in the schedule of benefits,
- insured under a government health insurance plan and reside in Canada,
- under age 75 for Basic Life Insurance, age 70 for Dependent Life Insurance and Optional Life Insurance, age 65 for Short Term Disability Benefits and Long Term Disability Benefits and age 70 for Extended Health Care Benefits and Dental Care Benefits, and
- have been employed for the number of months as per the Employer's selection.

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.

We consider you to be actively working if you are:

- actually working at your employer's place of business or a place where your employer requires you to work in Canada,
- able to perform and actually performing all the usual and customary duties of your occupation on a full pay status and on a regular and continuous basis for the number of hours regularly scheduled for that day, or
- absent due to scheduled vacation, weekends, statutory holidays or shift variances.

Eligible Dependents

Your dependent spouse and children will be eligible to participate in this plan on the date you are eligible or if later, the date he/she becomes an eligible dependent. To be eligible for coverage, each of your dependents must be insured under a provincial government health insurance plan and reside in Canada.

- Your spouse is your legal spouse or a person continuously living with you in a role like that of a marriage partner for at least 12 months. The 12 month requirement can be waived if you and your spouse have had or adopted a child together.
  - 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
  - is 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, in order for coverage to continue beyond the maximum dependent age you must submit a written application within 31 days of your child reaching age 21 and supply proof of infirmity, or status as a student.
- Your spouse's child is an eligible dependent if the child is also your natural or adopted child or your spouse is residing with you, covered 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 Co-operators Life have received satisfactory proof of guardianship. If your covered spouse is the guardian, your 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.

How do I apply for coverage?
Your employer/plan administrator can provide you with the group enrolment form and/or other forms necessary to apply for or change your group benefits coverage. You must enroll within 31 days of becoming eligible to join the plan. If you enrol after 31 days, your application will be considered late and you and your dependents will be required to provide health evidence of insurability.

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 Care Benefits plan and/or the Dental Care Benefits plan, you can choose to participate or not. If you participate you have the choice of single coverage, spouse coverage or family coverage.

What if I have comparable Extended Health Care Benefits and/or Dental Care Benefits under my spouse's plan?
If you are covered under your spouse's plan at the time of application, you may waive comparable coverage offered by this plan. You will be required to complete and sign the section titled decline option on the group enrolment form. If coverage under your spouse's plan terminates, either because the particular plan terminates or because your spouse becomes ineligible, you are eligible for immediate coverage under this plan if you apply within 31 days of the date your spouse's coverage terminates. For any application, after 31 days, evidence of insurability will be required and coverage will not be effective until the day the health evidence is approved.

Health Evidence of Insurability
When you submit your enrolment form, you may be asked to provide evidence of good health before coverage begins if:
- you or your dependents are a late applicant (you applied more than 31 days after becoming eligible),
- you apply for an amount of coverage that is more than the amount available without evidence of insurability,
- you apply for coverage you previously declined.

When does my coverage begin?
Your coverage takes effect on the later of the following dates, provided you are actively at work on that date:
- the date you satisfy the eligibility requirements provided you enrol within 31 days of becoming eligible
- if health evidence is required, the date your application is approved.

If you were not actively at work on the date your coverage would normally become effective or increase, then that coverage will not take effect until the first full day you are again actively at work.

When does coverage for my dependents begin?
Your dependent coverage takes effect the later of:
- the date your coverage begins
- the date your dependent becomes eligible for coverage
- if health evidence is required, the date the application is approved.

Extended health care coverage for a dependent who is hospitalized, other than a newborn child, will be delayed until the first day after his/her discharge from the hospital.

Updating your records:
To ensure that coverage is kept-up-to-date, it is important that you report changes to your employer/plan administrator as soon as possible:
- change of dependents
- loss of spousal benefits
- change of name or address
- change of beneficiary

Designating your beneficiary:
Your designated beneficiary receives any benefits payable under the basic life benefit and if applicable, optional life plans in the event of your death. As such, it's very important that you name a beneficiary when you enrol.

You have the right to name a beneficiary at the time you apply for coverage and you can change your beneficiary at any time, where permitted by law, by completing a form available from your employer/plan administrator. If your beneficiary dies before you do or if you do not name a beneficiary, payment will be made to your estate. If your beneficiary is a minor, payment will be made to the trustee (if you named one) or a public trustee (if you have not appointed a trustee for minor beneficiaries). A beneficiary named under the basic life benefit is, unless stipulated to the contrary, the beneficiary for all benefits under your plan. You should review any beneficiary designations under this plan from time to time to ensure that they reflect your current intentions.

When do changes in the amount of my coverage take effect?
Increase in coverage:
If the change would result in an increase, the increase will be effective on the later of:
- the date of the change,
- the first full day you return to work for full pay if you were not actively at work on the date of the change, and
- if health evidence is required, the date your application is approved.

Decrease in coverage:
Decreases will be effective on the date of the change.

What is meant by salary?

Your salary is your regular annual earnings (before deductions) paid to you by your employer not including bonuses, commissions, dividends, overtime earnings or moneys paid in lieu of holidays, or travelling expenses, subsistence allowance, housing allowance, settlement allowance, living allowance, honorarium, fees or and any other extra compensation. Your net salary is your gross earnings less deductions (taxes, EI and Canada or Quebec pension plan).

What happens if my salary is understated or overstated?

To determine the amount of your benefit at the time of claim, your salary will be the lesser of:

- the amount reported on your claim form, or
- the amount reported by your employer/plan administrator to Co-operators Life and for which premiums have been paid.

When does coverage end?

Your coverage terminates the earliest of:

- the date your employment terminates (including retirement)
- the date you are no longer actively at work (except for maternity/parental/family leave where legislated and educational leave)
- the date you are no longer actively at work (except for severance, temporary leave of absence or temporary lay-off) where coverage may be extended for the minimum period required by law for severances or up to 90 days for temporary leaves. The extension must be requested by your employer on a basis that does not discriminate against another employee and premiums and/or deposit payments must be paid
- the end of a period for which premiums and/or deposit payments have been paid for your coverage
- the date you cease to be in a class of employees eligible for coverage
- the date you reach the termination age specified in the schedule of benefits under each benefit, or
- the date your employer's group policy or plan text terminates

Your dependents' coverage terminates the earliest of:

- the date your coverage terminates
- the date your dependent is no longer an eligible dependent
- the end of a period for which premiums and/or deposit payments have been paid for dependent coverage

The Claims Process

Where do I find a claim form?

Claim forms are available from your employer, plan administrator or from our website at www.nebsnorth.com.

The Co-operators Life team in the Group Client Service Centre would also be happy to assist you via telephone, email, or you can ask a question though Benefits Now™ for Plan Members, their secure plan member website.

Visit www.cooperators.ca/groupbenefits>Plan Members and select Benefits Now™ for Plan Members to find details regarding your benefit plan. Once logged in, you can submit or check the status of a health or dental claim, sign up for direct deposit of claim funds to your bank account, print claim forms and find cost control tips, links to health and wellness sites and much more.

To avoid delays, complete the claim form in its entirety, and always include:

- your full name as it appears on your pay stub
- your personal identification number (i.e. certificate number)
- your employer's name, and
- your group policy/plan text number

Be sure to also include all supporting receipts and the explanation of benefits from another benefit plan. Remember to date and sign the claim form and keep a photocopy of your claim form and all supporting documents for your records.

How long will it take to process my claim?
This will depend on how you submit your claim and how you choose to receive payment. Send paper claims to the address printed on the claim form or access Benefits Now™ for Plan Members for electronic claims submission.

Health and dental e-claim submission offers a number of benefits over paper claim submission.

Faster – mailing time is eliminated
Convenient – access e-claim submission exclusively though Benefits Now™ for Plan Members
Sustainable – no need to complete a paper claim form
Reliable – you'll receive a message with your e-claim number to confirm receipt of your submission

As part of e-claims submission, you'll be asked to provide your banking information for direct deposit of claims payment and your email address for electronic notification (including claims confirmation). Because Co-operators Life will receive your claims faster and deposit your claims payments directly in your bank account, you'll receive your claims payment faster than with paper submission.

Health Care Claims
Health care claim forms must be completed by you and must be accompanied by receipts that give sufficient detail to assist in the settlement of the claim. Where your government health insurance plan provides a grant for covered medical services and supplies, you must also submit a copy of your grant notification. Claims for emergency out of Canada expenses must first be submitted to your provincial health plan for payment. Any outstanding balance should be submitted along with the explanation of payment from the provincial health plan.

Dental Claims
Dental claims and 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 submit a completed standard Dental Association claim form.

Prescription Drug Claims for Pay-direct Drug Card Plans
If you have a drug card plan, 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.

Proof of Claim

You are required to prove your entitlement to benefits under your plan and to provide notice of claim in accordance with the master policy or plan text provisions. You must provide information required to prove your entitlement to benefits and must also authorize Co-operators Life to obtain information from other sources for this purpose (if required). From time to time, you may be asked to provide proof of your total disability. Whenever information or authorization is requested, it must be submitted within the time limit requested. If not submitted within this time, you will not be entitled to benefits. Expenses incurred for providing this information will be your responsibility.

When should I submit my claim form?

To permit prompt assessment, initial notice of claim should be submitted no later than the time limits described in each benefit section.

After completion, Life, Dependent Life and Disability claim forms should be sent to:

Manager, Group Benefits Plans
Northern Employee Benefits Services
5122 53rd Street
Yellowknife, NT X1A 1V6

All Other Claim Forms can be mailed to:

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

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/plan text 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/Plan Text; 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/Plan Text 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/Plan Text, 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 covered benefits, you have the right, to request a copy of your enrollment form or application for coverage 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 covered benefits, on reasonable notice, you may also request a copy of the master policy/plan text subject to certain limitations. 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 Co-operators Life Group Client Service Centre.

Third Party Liability

If you and/or your covered dependent become totally disabled due to an injury or sickness or become eligible for reimbursement of covered medical or dental expenses as a result of an injury or sickness for which a third party is, or may legally become liable, you or your dependent must sign a reimbursement agreement and submit it to Co-operators Life before any benefits will be paid. The reimbursement agreement outlines the terms for reimbursing Co-operators Life when you settle the claim with the third party. To continue to qualify for any future benefits, it is important that you and/or your dependent obtain written consent from Co-operators Life before settling any claim with the third party.

BASIC LIFE INSURANCE BENEFIT

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

If you die while insured, Co-operators Life will pay the amount of basic life insurance for which you are insured, as described in the schedule of benefits, to your named beneficiary.

If you qualify for an amount of insurance in excess of the non-evidence maximum (NEM) shown in the schedule of benefits, your basic group life insurance may be increased to an amount not exceeding the health evidence maximum (HEM) shown in the schedule of benefits, provided Co-operators Life approve your health evidence application.

What if I become terminally ill?

The living assistance benefit is available to you as an advance payment of your basic life insurance to help meet your medical or other health and welfare expenses if you become terminally ill and have been approved for the total disability life waiver of premium (if applicable) prior to age 65.

Your employer must approve your application for this benefit and Co-operators Life will confirm that your medically diagnosed condition meets the program's requirements before approving payment. The amount of money available as a living benefit payment is 50% of your basic life insurance benefit, to a maximum of $50,000.

When to submit a life claim

Your beneficiary or estate must submit a claim within 6 months of the date of death.

If you become totally disabled (as defined in the policy) prior to age 65, you can apply for a premium waiver and if approved your life insurance coverage will continue without payment of premium until the earlier of; your 65th birthday or your recovery, retirement or death. Proof of your total disability must be submitted to Co-operators Life within 6 months from the date you became disabled and periodically thereafter.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after the date of loss or disability.

Life Insurance Conversion Privilege

Not applicable to Elected Councillors or Appointed Board Members

If your insurance terminates on or before your 65th birthday, you may be able to convert your group life insurance to an individual policy, without needing to provide evidence of good health. Your application for the individual policy and the first premium must be received by Co-operators Life within 31 days of the termination of your group life insurance. If your insurance terminates on your 65th birthday, your application must be received by Co-operators Life within 31 days of your 65th birthday. If you die during this period, the amount of group life insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The conversion privilege is not available after your 65th birthday.

Not all types of individual plans are available for conversion and the individual plan will not include any disability, accidental death benefits or any other special benefit. The maximum amount of group life insurance that can be converted cannot exceed the full amount of your basic life insurance benefit amounts less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective. However, in no event shall the amount of the individual policy exceed $200,000.

Depending on your plan specifics you may also be able to convert your spouse's optional life coverage to an individual policy. When you are entitled to convert coverage under another benefit provided under your plan, the sum of the amounts available for conversion cannot exceed $200,000. The individual life insurance contract becomes effective at the end of the 31 day conversion period.

If you are interested in applying for conversion, please contact a Co-operators office near you for an application form.

DEPENDENT LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

What am I insured for?
If an eligible dependent should die while you are insured under this benefit, the amount of dependent life insurance shown in the schedule of benefits will be paid to you.

Total Disability Waiver of Premium
If premiums for your basic life insurance coverage are being waived, premiums for the dependent life benefit will also be waived, but only so long as this benefit and your employer's coverage under this benefit remains in force.

When to submit a Dependent Life claim
The claim form must be submitted to Co-operators Life within 6 months from the date of death.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after the date of death.

OPTIONAL LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

What am I insured for?
You, your insured spouse and/or your dependent parent may apply for an additional amount of life insurance as indicated in the schedule of benefits.

How do I apply?
Written application should be made on the forms provided by Co-operators Life and coverage will not take effect until the first day of the month following the date that Co-operators Life approve the health evidence application, in writing. Co-operators Life will be responsible for the cost of medical fees incurred in obtaining any medical information required to proceed with the application.

Maximum Benefit
The amount of Optional Life insurance issued to you, your spouse and/or you dependent parent will not exceed the maximum indicated in the schedule of benefits.

Termination of Optional Life Benefits
The Optional Life Insurance will terminate on the occurrence of any of the following events:

- termination of your basic group life insurance
- termination of this optional life insurance benefit
- the cessation of premium payments for the Optional Life Insurance
- the date the covered person attains the termination age indicated in the schedule of benefits

Total Disability Waiver of Premium
If premiums for your basic life insurance coverage under the policy are being waived, then premiums for optional life insurance will also be waived.

Suicide
No benefit will be payable where the cause of death is suicide occurring within 2 years from the date the covered person's coverage became effective or within 2 years from the effective date of any increase.

When to submit an Optional Life claim
The claim form must be submitted to Co-operators Life within 6 months from the date of death.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after the date of death.

Life Insurance Conversion Privilege

Not applicable to Elected Councillors or Appointed Board Members

If your insurance terminates on or before your 65th birthday, you may be able to convert your group life insurance to an individual policy, without needing to provide evidence of good health. Your application for the individual policy and the first premium must be received by Co-operators Life within 31 days of the termination of your group life insurance. If your insurance terminates on your 65th birthday, your application must be received by Co-operators Life within 31 days of your 65th birthday. If you die during this period, the amount of group life insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion. The conversion privilege is not available after your 65th birthday.

Not all types of individual plans are available for conversion and the individual plan will not include any disability, accidental death benefits or any other special benefit. The maximum amount of group life insurance that can be converted cannot exceed the full amount of your basic life insurance benefit amounts less the amount of insurance you have or are eligible for under any group insurance contract issued by any insurance carrier on the date your converted policy becomes effective. However, in no event shall the amount of the individual policy exceed $200,000.

Depending on your plan specifics you may also be able to convert your spouse's optional life coverage to an individual policy. When you are entitled to convert coverage under another benefit provided under your plan, the sum of the amounts available for conversion cannot exceed $200,000. The individual life insurance contract becomes effective at the end of the 31 day conversion period.

If you are interested in applying for conversion, please contact a Co-operators office near you for an application form.

SHORT TERM DISABILITY BENEFITS (STD)

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

Your short term disability coverage is designed to provide you with income protection if you become totally disabled (as defined in the policy) while insured under this plan. You may become eligible for benefits after satisfying the elimination period indicated in the schedule of benefits.

Independent Medical Assessment

It is a condition prior to the initial payment of benefits and any continuing payment of benefits that if Co-operators Life require, you will undergo medical assessment(s) by one or more medical practitioners chosen by Co-operators Life.

Participation in Rehabilitation Program

It is a condition prior to and while you are receiving benefits, that you will participate in any rehabilitation program that Co-operators Life consider appropriate, including but not limited to rehabilitation program offered through worker's compensation legislation or similar statute.

Payment of Short Term Disability Benefits

Co-operators Life will pay a weekly benefit after Co-operators Life receive satisfactory proof that you:

- are and have been totally disabled since the disability date,
- have suffered a loss of income,
- are receiving and following reasonable and customary treatment prescribed and rendered by a general physician or a specialist if Co-operators Life consider it appropriate, and
- have satisfied all of the other relevant conditions contained in the policy,

When will benefits begin?

Your benefits will begin the day following the end of the elimination period indicated in the schedule of benefits. The elimination period is the period of time you must be disabled before you qualify to make a claim for benefits.

How long will benefits be paid?

Benefits will not continue past the number of weeks from the date you became disabled, as indicated in the schedule of benefits.

Recurrence of Total Disability

Your total disability is considered a recurrence if it arises from the same or related sickness or injury within 4 weeks from the date your benefits ended.

Benefits are pro-rated for partial weeks

Benefits payable for periods less than a full week will be pro-rated at 1/5th or 1/7th (as indicated in the schedule of benefits).

Are my benefits taxable?

Your benefit payments are taxable if your employer pays any portion of the premium. According to information provided by your employer and Co-operators Life current records the tax status is stated in the schedule of benefits.

Rehabilitation Program

A rehabilitation program is a program provided at the sole discretion of Co-operators Life. If you participate in rehabilitative employment approved by Co-operators Life your benefit will be reduced by 50% of your rehabilitative earnings. The weekly benefit payable during rehabilitative employment will be calculated after 2 weeks of earnings have been reported to Co-operators Life, payable weekly and adjusted periodically.

Your benefit may be further reduced by any amount necessary to reduce the total income you receive from all sources to 100% of the weekly salary for which you were insured immediately prior to the start of your disability. If your benefit is non-taxable, your total income from all sources will be limited to 100% of the salary for which you were insured immediately prior to the start of your disability less your deductions for income tax, EI and CPP/QPP.

Your Short Term Disability benefits will cease on the earliest of:

- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by Co-operators Life including but not limited to any rehabilitation program offered through, workers compensation legislation or similar statute, auto plan benefits or Canada Pension Plan, or
- the withdrawal of your rehabilitation program

Benefit Reductions:

All Source Maximum - Ceiling on the Short Term Disability Benefit

Your benefit will be limited to the lesser of the amount of insurance for which you are covered or the all source maximum indicated in the schedule of benefits.

All Source compensation - Direct Reductions

Your benefit will be reduced directly by one or more of the following, which you are receiving or entitled to receive at the time your benefits commence and/or while benefits, are paid:

- any government plan benefits.

All Source Compensation - Indirect Reductions

Your benefit will be further reduced if the total of the following all source compensation and your weekly benefit exceeds the all source maximum indicated on the schedule of benefits, by:

- any auto plan benefits,
- any Canada or Quebec pension plan retirement benefits you apply for, were approved for and received after your disability date,
- any compensation for loss of income you receive from a third party or are entitled to receive after your disability date.
- any amount you are entitled to under an employer funded salary replacement benefit as a result of your disability, and
- any compensation you receive or are eligible to receive while employed or while performing work of any sort, excluding rehabilitative earnings which are considered under the rehabilitation program, and
- any payment made to you by your employer as a result of termination of your employment including without limitation any payment made by way of settlement or judgement, and
- any disability benefits you are eligible to receive under any other group or association plan as a result of being an employee of a group or a member of an association.

Failure to Apply for Other Benefits
Except for retirement benefits, any benefit is considered paid when you are entitled to it, whether or not it has been awarded or received. If it has not been awarded or received, Co-operators Life have the right to estimate the income according to the terms of any plans or legislation involved. Retirement benefits are considered payable when they are actually received.

Where you do not qualify for part or all of the all source compensation because of failure to apply in a timely and satisfactory manner (or appeal where so advised by Co-operators Life), Co-operators Life reserves the right to reduce your benefit by the amount which you would have been eligible for or received had a proper application or appeal been made.

Lump Sum Conversion to Weekly Benefit
Where you receive or have the option of receiving part or all of the all source compensation as a lump sum payment, Co-operators Life will, acting reasonably, pro-rate the lump sum payment and reduce your benefit as if the lump sum had been paid on a weekly basis.

Repayment of Benefits
Where you receive all source compensation that includes compensation for a period for which benefits have been paid, Co-operators Life will convert the payment to a weekly payment and recalculate your benefit that should have been paid. You are responsible to repay Co-operators Life any overpayment.

Total Disability Waiver of Premium
Premiums will be waived while you are receiving disability benefits retroactive to your initial date of total disability.

When do my Short Term Disability Benefits Terminate?

No benefits will be paid beyond:
- the number of weeks as indicated in the schedule of benefits, or
- the date you cease to be totally disabled, or
- the date you begin working in any occupation, except in an approved rehabilitation program, or
- the date you reach the termination age as indicated in the schedule of benefits. However, if you are totally disabled on this date, you will, subject to satisfying any other conditions in the policy, be entitled to a maximum of 15 weeks of benefits, or
- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by Co-operators Life including but not limited to any rehabilitation program offered through workers compensation legislation or similar statute or
- the date you refuse to participate or co-operate in a reasonable and customary treatment program approved by Co-operators Life, or
- the date of your death, or
- the date you retire, or were scheduled to retire, or
- the date you withdraw or receive employer funded pension funds.

A reasonable and customary treatment program is systematic treatment that is:
- generally accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of the medically diagnosed condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the medically diagnosed condition involved, and
- prescribed and rendered by a physician or where considered appropriate by Co-operators Life for the nature of the medically diagnosed condition, the treatment must be prescribed and rendered by a specialist.

No benefits will be payable during any period while you are:

- serving a sentence for a criminal or provincial offense whether you are imprisoned in a half-way house, a correctional facility, or any other form of detention, or
- becomes disabled during a work stoppage, including but not limited to strike, lock-out or suspension, or
- on a temporary leave of absence or maternity/parental or compassionate (family) leave and receiving or eligible to receive employment insurance (EI) benefits or maternity or parental benefits from any other source, except as provided below:

Maternity/Parental/Compassionate Leave or Temporary Leave or Lay-off

If you become totally disabled while on maternity/parental/compassionate leave, temporary leave or lay-off, provided premiums have been paid the elimination period will commence on your disability date and benefits will begin on the later of the end of the elimination period or the date you were scheduled to return to active work.

A scheduled leave is deemed to commence on the date agreed upon by you and your employer and end on the date you were scheduled to return to active work. If a child is born prior to the date upon which your maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

If your employer is required to provide benefits during the health related portion of your maternity leave as a result of law or legislation, the elimination period will begin on the date your child is born and benefits will begin after you have satisfied the elimination period.

What limitations are there on STD benefits?

No Short Term Disability Benefits will be payable for any period of total disability resulting directly or indirectly from any of the following:

- insurrection, war (whether declared or not), voluntary participation in a civil riot or commotion, or
- committing or provoking an assault, committing or attempting to commit a criminal offense, or
- a situation where the disability results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving a vehicle involved in the accident and had either:
  - alcohol in your blood in excess of 80 milligrams of alcohol per hundred millilitres of blood, or
  - your ability to operate the vehicle impaired by drugs or alcohol or a combination of the two, or
- any injury or sickness for which a third party is, or may legally be liable, except as provided for under the third party liability provision in the policy, or
- medical care which is not medically necessary to treat an injury or sickness, except for as provided below:
  - disability due to medical care that is not medically necessary may be eligible for benefits if you are disabled more than 14 days
  - disability due to the donation of an organ or tissue will be considered as necessary medical care

When to submit a STD claim

Co-operators Life must receive written notice of a claim for Short Term Disability benefits within 30 days from the end of the elimination period. Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 90 days from the end of the elimination period.

LONG TERM DISABILITY BENEFITS

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

To qualify for benefits, your claim must provide satisfactory proof that, while insured under this plan, you became totally disabled (as that term is defined in the policy) and therefore unable to work.

The purpose of this benefit is to insure for wage loss should you become totally disabled as a result of a medically diagnosed sickness or injury and unable to work. Therefore, if there is no lost income, benefits are not payable.

The monthly benefit for which you are covered is based on your monthly salary and the benefit formula indicated in the schedule of benefits. The amount payable is the monthly benefit amount less the reductions listed under the benefit reduction section in this booklet.

Excess Long Term Disability Insurance:

If your salary qualifies you for an amount of insurance in excess of the non-evidence maximum (NEM) shown in the schedule of benefits, your long term disability insurance may be increased to an amount not exceeding the health evidence maximum (HEM) shown in the schedule of benefits, provided evidence of good health is approved in writing by Co-operators Life.

What conditions do I need to satisfy before and during payment of benefits?

Independent Medical Assessment

It is a condition prior to the initial payment of benefits and any continuing payment of benefits that you will, if Co-operators Life requires, undergo medical assessment(s), by one or more medical practitioners chosen by Co-operators Life.

Continuous Obligation

Your obligation to undergo medical assessment exists during any period for which you claim benefits.

Participation in Rehabilitation Program

It is a condition prior to and while you are receiving benefits, that you will, where requested by Co-operators Life, participate in a rehabilitation program considered appropriate by Co-operators Life, including but not limited to an approved rehabilitation program offered through worker's compensation legislation or similar statute.

Pre-existing Condition Limitation

Pre-existing condition means a sickness or injury for which you sought medical investigation, diagnosis, diagnostic measures, treatment, care medication or medical advice, or for which there were symptoms which would have caused a person acting reasonably to seek medical investigation, diagnosis, diagnostic measures, care, treatment, medication or medical advice within the 12 month 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 12 months immediately following the effective date of your long term disability coverage, or
- you have been insured continuously under this long term disability plan for at least 12 months (from the date your insurance became effective or reinstated) 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.

Payment of Monthly Benefits

During the own occupation period

Where Co-operators Life receives satisfactory proof that you:

- are and have been totally disabled since the disability date,
- have suffered a loss of income,
- are receiving and following reasonable and customary treatment prescribed and rendered by a general physician or specialist where considered appropriate by Co-operators Life, and
- have satisfied all of the other relevant conditions contained in the policy,

Co-operators Life will, subject to the provisions of the policy, pay to you a monthly benefit effective the day following the completion of the elimination period and payable for the maximum duration of your own occupation period as indicated in the schedule of benefits.

After the own occupation period

Where Co-operators Life receive satisfactory proof that you:

- are and have been totally disabled since the disability date,
- have suffered a loss of income,
- are receiving and following reasonable and customary treatment prescribed and rendered by a physician or where Co-operators Life consider appropriate, a specialist, and
- have satisfied all of the other relevant conditions contained in the policy,

Co-operators Life will, subject to the provisions of the policy, continue to pay you a monthly benefit.

When will benefits begin?

Your benefits will begin the day following the end of the elimination period indicated in the schedule of benefits or the day following the end of the period during which you are receiving short term disability benefits under this plan or salary continuation benefits from any other source, whichever is later.

The elimination period refers to the time frame of total disability that must be satisfied before you qualify to make a claim for benefits. Benefits are not payable and premiums are not waived during this period.

What if I work during the Elimination Period?

If you return to active work for 7 consecutive days or less, your elimination period will be considered to be uninterrupted, but the days you worked will be added to the end of your elimination period. If you return to active work for more than 7 days, your elimination period will be reinstated and you will be required to satisfy the complete elimination period before benefits are eligible to be paid.

Recurrence of Total Disability

Your total disability is considered a recurrence if it arises from the same or related sickness or injury within 6 months from the date your benefits ended.

Benefits are pro-rated for partial months

Monthly benefits payable for periods less than a full month will be pro-rated based on the actual number of days in the applicable month.

Are my benefits taxable?

Your benefit payments are taxable if your employer pays any portion of the premium. According to information provided by your employer and Co-operators Life current records the tax status is stated in the schedule of benefits.

Rehabilitation Program
A Rehabilitation Program is provided at Co-operators Life discretion and may include rehabilitation assessment, and/or rehabilitative employment, and/or rehabilitative treatment, and/or rehabilitation services recommended and approved by Co-operators Life.

Approval of Rehabilitation Program
Co-operators Life will have sole discretion in determining whether or not a rehabilitation program is appropriate and/or provided for any employee. Once the rehabilitation program is approved, Co-operators Life may issue, if eligible, monthly benefits to a totally disabled employee who continues to participate and co-operate in an approved rehabilitation program.

The rehabilitation program duration will be determined by Co-operators Life, however it will not extend beyond the end of the own occupation period indicated in the schedule of benefits or 24 months from the date of your disability, whichever is later, unless an extension of the duration is recommended and approved in writing by Co-operators Life.

Calculation of Monthly Benefits during a rehabilitation employment period
If you participate in rehabilitative employment approved by Co-operators Life, your benefit will be reduced by 50% of your rehabilitative earnings. The monthly benefit payable during rehabilitative employment will be calculated after 4 weeks of earnings have been reported to Co-operators Life, payable monthly and adjusted periodically.

Your benefit may be further reduced by any amount necessary to reduce the total income you receive from all sources to 100% of the monthly salary for which you were insured immediately prior to the start of your disability. If your benefit is non-taxable, your total income from all sources will be limited to 100% of the salary for which you were insured immediately prior to the start of your disability less your deductions for income tax, EI and CPP/QPP.

Your monthly benefits will cease on the earliest of:
- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by Co-operators Life including but not limited to any rehabilitation program offered through any worker's compensation legislation or similar statute, auto plan benefits or Canada Pension Plan, or
- the withdrawal of Co-operators Life approval of your rehabilitation program.

Benefit Reductions:
What reductions occur when determining my Monthly Indemnity Benefit payment?

All Source Maximum - Ceiling on the Monthly Benefit
For non-taxable long term disability plans, the amount of your non-taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 85% of your pre-disability net monthly salary.

Your net salary is your gross salary minus involuntary deductions for federal and provincial income tax, employment insurance premiums (EI) and Canada/Quebec Pension Plan contributions.

For taxable long term disability plans, the amount of your taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 85% of your pre-disability gross monthly salary.

All Source Compensation - Direct Reductions

Your monthly benefit will be reduced directly by one or more of the following, which you are receiving or entitled to receive at the time your benefits commence and/or while benefits, are paid:

- any government plan benefits.

All Source Compensation - Indirect Reductions

Your benefit will be further reduced if the total of the following all source compensation and your monthly benefit exceeds 85% of your pre-disability gross monthly salary for taxable plans, your net monthly salary for non-taxable plans. If it does, your monthly benefit will be reduced by the amount in excess of 85% by:

- any auto plan benefits,
- any Canada or Quebec Pension Plan retirement benefits you apply for, were approved for and received after your disability date,
- any compensation for loss of income you receive from a third party or are entitled to receive after your disability date.
- any amount you are entitled to under an employer funded salary replacement benefit as a result of your disability, and
- any compensation you receive or are eligible to receive while employed or while performing work of any sort, excluding rehabilitative earnings which are considered under the rehabilitation program, and
- any payment made to you by your employer as a result of termination of your employment including without limitation any payment made by way of settlement or judgement, and
- any disability benefits you are eligible to receive under any other group or association plan as a result of being an employee of a group or a member of an association.

Failure to Apply or Accept Other Benefits

Except for retirement benefits, any benefit is considered paid when you are entitled to it, whether or not it has been awarded or received. If it has not been awarded or received, Co-operators Life will have the right to estimate the income according to the terms of any plans or legislation involved. Retirement benefits are considered payable when they are actually received.

Where you do not qualify for part or all of the all source compensation because of failure to apply in a timely and satisfactory manner (or appeal where so advised by Co-operators Life), Co-operators Life reserves the right to reduce your monthly benefit by the amount of all source compensation which you would have been eligible for or received had a proper application or appeal been made.

Lump sum conversion to Monthly Benefit

Where you receive or have the option of receiving part or all of the all source compensation as a lump sum payment, Co-operators Life will, acting reasonably, pro-rate the lump sum payment and reduce your monthly benefit as if the lump sum had been paid on a monthly basis.

Repayment of Benefits

Where you receive all source compensation that includes compensation for a period for which monthly benefits have been paid, Co-operators Life will convert the payment to a monthly payment and recalculate your monthly benefit that should have been paid. You are responsible to repay Co-operators Life any overpayment of long term disability benefits.

Total Disability Waiver of Premium

Co-operators Life will waive your long term disability premiums while you are receiving benefits.

When do my Long Term Disability Benefits terminate?

No monthly benefits will be paid beyond:

- the date you cease to be totally disabled, or
- the benefit duration indicated in the schedule of benefits or your 65th birthday, whichever first occurs, or
- the date you begin working in any occupation, except as provided for under the rehabilitation program, or
- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by Co-operators Life including but not limited to any rehabilitation program offered through workers compensation legislation or similar statute, or
- the date you refuse to participate or co-operate in a reasonable and customary treatment program approved by Co-operators Life, or
- the date of your death, or
- the date you retire, or were scheduled to retire, or
- the date you withdraw or receive employer funded pension funds.

A reasonable and customary treatment program is systematic treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of the medically diagnosed condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the medically diagnosed condition involved, and
- prescribed and rendered by a physician or where considered appropriate by Co-operators Life for the nature of the medically diagnosed condition, the treatment must be prescribed and rendered by a specialist.

No monthly benefits will be payable during any period while you are:

- serving a sentence for a criminal or provincial offense whether you are imprisoned in a half-way house, a correctional facility, or any other form of detention, or
- absent from Canada longer than 3 months due to any reason, unless Co-operators Life agree in writing in advance to continue to pay your benefits during this period, or
- receiving short term disability benefits under this plan or salary continuation benefits from any other source, or
- on maternity/parental or compassionate (family) leave and receiving or eligible to receive employment insurance (EI) benefits or maternity or parental benefits from any other source, or
- becomes disabled during a work stoppage, including but not limited to strike, lay-off, lock-out, suspension or leave of absence, except as provided below:

Maternity/Parental/Compassionate Leave or Temporary Leave or Lay-off

If you become totally disabled while on maternity/parental/compassionate leave, temporary leave or lay-off, provided premiums have been paid the elimination period will commence on your disability date and benefits will begin on the later of the end of the elimination period or the date you were scheduled to return to active work.

A scheduled leave is deemed to commence on the date agreed upon by you and your employer and end on the date you were scheduled to return to active work. If a child is born prior to the date upon which your maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

If your employer is required to provide benefits during the health related portion of your maternity leave as a result of law or legislation, the elimination period will begin on the date your child is born and benefits will begin after you have satisfied the elimination period.

What limitations are there on LTD benefits?
No monthly benefits will be payable for any period of disability resulting directly or indirectly from any of the following:

- insurrection, war (whether declared or not), voluntary participation in a civil riot or commotion, or
- committing or provoking an assault, committing or attempting to commit a criminal offense, or
- a situation where the disability results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving a vehicle involved in the accident and had either:
  - alcohol in your blood in excess of 80 milligrams of alcohol per hundred millilitres of blood
  - your ability to operate the vehicle impaired by drugs or alcohol or a combination of the two
- medical care which is not medically necessary to treat an injury or sickness or which is of a cosmetic nature. The donation of an organ or tissue will be considered necessary medical care, or
- any injury or sickness for which a third party is, or may legally be liable, except as provided for under the third party liability provision in the policy.

When to submit an LTD claim
Co-operators Life must receive written notice of a claim for monthly benefits within 60 days from the end of the elimination period.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 180 days from the end of the elimination period.

If you are totally disabled and receiving benefits under any worker's compensation legislation or similar statute, you should still submit an application for long term disability benefits to Co-operators Life according to the above procedure. You may also be eligible to receive Canada Pension Plan (CPP) or Quebec Pension plan (QPP) disability benefits. Applications can be obtained from your nearest CPP or QPP office.

EXTENDED HEALTH CARE BENEFITS

Coverage administered by Co-operators Life Insurance Company

What am I covered for?

This benefit helps pay the cost of eligible medical and hospital expenses incurred by you and your covered dependents. You will be reimbursed for incurred allowable expenses, subject to the deductible, co-coverage amounts and benefit maximums stated in the schedule of benefits.

Is pre-determination of certain benefits necessary?

Co-operators Life recommend that for any expenses that are likely to exceed $400, a detailed treatment plan should be submitted before the treatment begins. This procedure will identify the cost you may be responsible for and will provide you with an opportunity to seek an alternative course of treatment, if necessary. In order for benefits to be paid, you must be eligible for coverage on the date the expense is actually incurred.

Assessment Standard:

All allowable expenses covered under the health care benefit must represent reasonable and customary treatment of the covered person's medically diagnosed condition.

Reasonable and Customary Treatment means systematic treatment that is:

- generally accepted and recognized by the Canadian medical profession as effective appropriate and essential in the treatment of the medically diagnosed condition, and
- of a nature, intensity, frequency and duration essential to the diagnosis or management of the medically diagnosed condition involved; and
- prescribed and rendered by a physician or where considered appropriate by Co-operators Life for the nature of the medically diagnosed condition, the treatment must be prescribed and rendered by a specialist.

The physician, specialist or any other medical practitioner cannot be related to the covered person or work with or reside in the covered person's home.

Allowable Expenses:

Allowable expenses are the lesser of the actual charges and reasonable and customary expenses for covered services and supplies.

Payment will be made for those allowable expenses, which:

- represent reasonable and customary treatment of the covered person's medically diagnosed condition, and
- are incurred while you and your dependents are covered under this plan

Reasonable and Customary Expenses are the lowest of:

- the representative prices in the area where the service or supply or prescription drug was provided, including but not limited to the pharmacy dispensing fees, the mark-up price and the ingredient costs
- the prices shown in any applicable professional association fee guide, or
- the maximum prices established by law

Co-coverage Levels and Deductible Amounts

Allowable expenses are reimbursed at the co-coverage level indicated in the schedule of benefits. Extended health care benefits are subject to any maximums identified for the covered services or supplies.

The deductible amounts are shown in the schedule of benefits. This is the amount you must pay before any benefits become payable under your plan. The deductible amounts do not apply to certain expenses identified in the schedule of benefits. The co-coverage or co-payment amount is the portion of the expense that is covered under your plan.

Date Expenses are incurred
For the purposes of all calculations made under the health care plan, allowable expenses for services and supplies are considered to be incurred when the covered person receives them.

Covered Extended Health Care Services and Supplies:
To qualify for coverage the covered person (you and your covered dependents) must be covered by a government health insurance in Canada.

Any benefit otherwise payable under this plan will be reduced by any amount the covered person received or is eligible to receive from:

- any government health insurance plan, or
- worker's compensation legislation or any similar statute, or
- any government hospital, medical, dental or health care plan, whether payable or not.

Where your government health insurance plan provides a grant in lieu of actual reimbursement for medical services and supplies, covered persons will be deemed to have received the maximum grant available unless their "grant notification" states otherwise. The covered person must submit a copy of the grant notification together with all original receipts and a signed claim form to Co-operators Life for consideration.

Ambulance Services
Expenses for transportation by ambulance, including air ambulance, are covered if they are provided by a licensed ambulance company. Transportation must be to the nearest approved hospital where reasonable and customary treatment is available, or from an approved hospital to a convalescent hospital. When medically necessary, the fee for 1 person to accompany the covered person when being transported will be covered.

Hospital Accommodation
Hospital care is covered if:

- it starts while the covered person is covered under this health care benefit, and
- it represents acute, convalescent or palliative care.

No benefits will be paid for hospital 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 plan.

Coverage is provided for the difference between the approved hospital's standard ward rate and the hospital accommodation shown in the schedule of benefits provided that accommodation was specifically elected in writing by the covered person. The hospital must have facilities for diagnostic, medical treatment and major surgery on the premises and coverage does not include accommodation in a nursing home, rest home, home for the aged or chronically ill, sanatorium or facility for treating alcohol or drug abuse.

Coverage is also provided for any out-of-province or out-of-territory out-patient charge in an approved hospital not covered by the provincial government health insurance plan in the covered person's province or territory of residence.

Benefits for hospital services outside Canada are payable only as provided under the out-of-country emergency care provision.

Convalescent Hospital Accommodation
Co-operators Life covers accommodation in a convalescent hospital for a medically diagnosed condition that requires convalescent care. Accommodation in a convalescent hospital must immediately follow at least 3 or more days of confinement in an approved hospital for a medically diagnosed condition that required acute care.

Co-operators Life covers the difference between the convalescent hospital's standard ward rate and the hospital accommodation shown in the schedule of benefits. For out-of-province or out-of-territory hospital accommodation in Canada, any difference between the convalescent hospital's standard ward rate and the government health insurance plan authorized allowance in the covered person's home province or territory is also covered.

Convalescent hospital accommodation is limited to the number of days indicated in the schedule of benefits. The maximum will be reinstated for a subsequent period of convalescent hospital accommodation when:

- it follows a period of at least 30 days during which no approved hospital or convalescent hospital confinement was required, or
- it is required for a medically diagnosed condition unrelated to the conditions for which benefits have already been paid.

Medically diagnosed conditions are considered related when they exist simultaneously or they arise from the same or related causes.

Coverage does not include accommodation in a nursing home, rest home, home for the aged or chronically ill, sanatorium or facility for treating alcohol or drug abuse.

Convalescent Nursing Expenses
Charges for necessary out-of-convalescent hospital services of a registered nurse or registered nursing assistant, provided the services are ordered by a physician, and medically necessary, and the nurse is not resident in the patient's home or a relative of the patient.

Out-of-convalescent hospital nursing services must commence within 48 hours following discharge from the hospital and charges are limited to the maximum indicated in the schedule of benefits.

A new maximum duration will not become available if the covered person has not been confined to either a hospital or convalescent hospital for a period of at least 30 days if subsequent confinement is due to any entirely unrelated sickness or injury.

Home Nursing Care
Home nursing care is covered if:

- it starts while the covered person is covered under this health care plan, and
- 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 plan.

Pre-determination of Home Nursing Care Benefits
To establish the amount of coverage available under this provision before home nursing begins, you **must** apply for a pre-determination of 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, you 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 you of the coverage that will be provided. Co-operators Life reserve 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 plan.

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 does not normally reside in the covered person's home and 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 recognized 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.

The maximum amount payable is shown in the schedule of benefits.

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.

Medically diagnosed condition or medically diagnosed means a sickness or an injury which has been diagnosed according to a generally accepted classification system including but not limited to an x-ray, MRI, bone scan, biopsy, CT scan, psychometric testing including MMPI-2, or a haematological or ultrasonic test.

Out-of-Country Emergency Care

Out-of-Country Emergency care is provided for the number of days of travel indicated in the schedule of benefits if:

- it is required as a result of a medical emergency arising while the covered person is travelling outside Canada for vacation, business or education, and
- the covered person is covered by a government health insurance plan in Canada

Co-operators Life covers the reasonable and customary charges, in excess of the coverage provided by the covered person's provincial government health insurance plan, for the following services and supplies when related to the initial emergency medical treatment:

- treatment by a physician
- diagnostic x-ray and laboratory services
- approved hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while the covered person is covered
- medical supplies provided during a covered hospital confinement
- paramedical services provided during a covered hospital confinement
- hospital out-patient services and supplies
- medical supplies provided out-of-hospital if they would have been covered in Canada
- prescription drugs
- out-of-hospital services of a professional nurse
- ambulance services include air ambulance, by a licensed ambulance company to the nearest centre where essential treatment is available
- dental accident treatment if it would have been covered under this health care plan had it been provided in Canada

A Medical Emergency means a sudden, unexpected injury or an acute episode of disease. Emergency Medical Care does not include medical attention for the monitoring of a stabilized condition.

If the covered person's medically diagnosed condition permits a return to Canada, benefits are limited to the lesser of:

- the amount payable under this plan for continued treatment outside Canada, and
- the amount payable under this plan for comparable treatment in Canada

If you are referred by a physician to an approved hospital outside of your province or territory of residence for medically necessary treatment which is unavailable in your province or territory and for which there is no medically sufficient alternate treatment available in your province or territory of residence and for which charges are eligible for reimbursement in whole or in part by the provincial or territorial medical plan, the charges listed above are covered.

Dependent students outside Canada

Because dependents studying outside Canada are not eligible for emergency out-of-country coverage after the duration indicated in the schedule of benefits, it's important that you purchase alternate coverage, such as travel insurance, before your dependent student leaves Canada.

Travel Benefits Plus

The following additional travel benefits are provided if:

- the loss is a covered out-of-country or out-of-province/out-of-territory medical emergency or
- the loss is a covered medical emergency that occurred within the covered persons province or territory 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 or territory 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 or territory 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, Co-operators Life recommend that you register with the Canadian embassy in the country you are visiting.

Emergency medical travel assistance

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/plan text 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.

Paramedical Practitioners Services

Reasonable and customary expenses for out-of-hospital services provided by the practitioners listed in the schedule of benefits, when treating a medically diagnosed condition are covered when provided in Canada. The maximum benefit available per covered person in any calendar year is indicated in the schedule of benefits. Unless prohibited under government health insurance plan legislation or specifically stated otherwise in the schedule of benefits, Co-operators Life will pay for the portion of the cost that is not payable under the covered person's government health insurance plan in their province or territory of residence, subject to the deductible and co-coverage amounts indicated in the schedule of benefits.

To be eligible for reimbursement, the paramedical practitioner must be registered as a member of a paramedical profession and licensed to practice in the province or territory in which treatment was provided. The practitioner's professional designation is required when you submit a claim. The information is usually on your receipt or is available from your practitioner. Licensed, certified or registered means licensed, certified or registered to practice by the appropriate authority in the province or territory in which the services are rendered. Where no such authority exists, the practitioner must have a certificate of competency from the professional body which establishes standards of competency and conduct for their profession that is equivalent to the established standards of practice required by the appropriate authority in regulated provinces or territories. The practitioner cannot work with or be related to the covered person or reside in the covered person's home.

Optometrists/Ophthalmologist Expenses for Eye Exams
Charges for eye examinations by a licensed ophthalmologist or optometrist provided these expenses are indicated as covered in the schedule of benefits and no portion of the cost is covered by the government health insurance plan. Charges will not exceed the maximum indicated in the schedule of benefits.

Prescription Drugs
The covered person is required to pay a co-payment or deductible amount as indicated in the schedule of benefits.

Co-operators Life will cover the reasonable and customary expenses for the following drugs required to treat a medically diagnosed condition that are listed under the drug plan indicated in the schedule of benefits.

(i) drugs, serums and vaccines that require a prescription from a physician, dentist or other health care provider legally licensed to order specified drugs within their province or territory of jurisdiction, according to:
- the Food and Drugs Act, Canada, and
- provincial legislation in effect where the drug is dispensed

Note: contraceptive drugs are covered

(ii) extemporaneous preparations or compound mixtures must contain at least one active prescription by law 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 similar to a commercially available pre-manufactured drug.

(iii) life sustaining drugs that do not require a prescription by law are covered if:
- they are prescribed by a health care provider legally licensed to do so within the province or territory; and
- they are considered a life sustaining drug, for example: insulin, nitroglycerin for immediate release.

Prescription Drug Limitations
No prescription drug benefits will be paid for:
- any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada.
- any drugs, medications or products that can be purchased over the counter (OTC).
- any drug categorized as acute will be covered up to a 34 day supply if the prescriber indicates this or up to 100 day supply for maintenance drugs. The maximum allowable supply may be limited to a lesser amount if the drug requires prior authorization.
- charges for any prescription drugs beyond the maximum dosage/quantity for a covered person's course of treatment.
- drugs dispensed by a physician, dentist or other health care provider or clinic or by a non-accredited hospital pharmacy.
- drugs dispensed during treatment as an in-patient or an out-patient in an approved hospital.
- drugs that are considered cosmetic, such as topical minoxidil for hair loss or sunscreens, whether or not prescribed for a medical reason.

- fees for the administration of any injectable drugs, including but not limited to serums, vaccines, vitamins, insulin, and allergy extracts.
- allergy serums, most vitamins, vaccines (unless these are specifically covered under your drug plan), health foods, nutritional supplements, growth hormones, homeopathic, naturopathic or herbal drugs, lozenges, dental products and mouthwashes.
- drugs prescribed for the treatment of sexual dysfunction, infertility, obesity or smoking cessation whether or not prescribed for a medical reason, unless otherwise indicated as covered in the schedule of benefits.
- drugs which would have been payable by the provincial plan if proper application had been made.
- drugs that are not recognized as an official indication of approved use by Health Canada for the covered persons medically diagnosed condition.
- drugs that are not recommended by the Canadian Agency for Drugs and Technologies in Health (CADTH) for the covered person's medically diagnosed condition.
- drugs that are recommended with any conditions by CADTH for the covered person's medically diagnosed condition.
- drugs will be limited to the lowest priced interchangeable/equivalent unless otherwise indicated in the schedule of benefits.

Specialty Drugs and Prior Authorization

Certain prescription drugs require prior authorization from Co-operators Life before being eligible for reimbursement. Prior authorization is a process where Co-operators Life, in writing, must first approve coverage for specialized or expensive prescription drug therapies based on certain medical criteria. Expenses for these prescription drugs will only be eligible for reimbursement if specific clinical criteria determined by Co-operators Life are met and the covered person received prior authorization from Co-operators Life. You or your dependent must have the prior authorization form completed by a physician at your own expense.

Provincial Government Drug Plans

Covered persons who are a resident of any province or territory in Canada where prescription drug expenses are covered through any provincial Government Health Insurance Plan, may be eligible to have a portion of the prescription drug expense paid for by the provincial government drug plan.

Prescription drug coverage under this plan, supplements the coverage provided by the provincial plan and will typically cover eligible drug expenses not reimbursed under the government program. Therefore, covered expenses for drugs that are eligible under any provincial Government Health Insurance Plan are limited to any deductible and co-coverage amounts the covered person is required to pay.

The covered person must enrol in the provincial government drug program even if the prescription drugs are covered under this plan. This will avoid delays when processing drug claims under this plan. Without confirmation of the covered person's enrolment in the provincial drug program, claims will only be paid up to an established threshold determined by Co-operators Life. If the covered person reaches the threshold and has not provided confirmation of enrolment, subsequent claims will be rejected until proof of enrolment in the provincial drug program has been received. Coverage for eligible drug expenses not covered by the provincial plan will resume once a copy of the confirmation of enrolment has been received by Co-operators Life.

Prescription Drugs Benefit Maximums

The maximum amount payable for prescription drug expenses in a calendar year is unlimited unless indicated otherwise in the schedule of benefits.

Medical Supplies

Reasonable and customary charges for the medical supplies described under this section are covered when prescribed by a physician or other health care provider legally licensed to prescribe these services or supplies, for reasonable and customary treatment of a medically diagnosed condition. For supplies available on a rental basis, Co-operators Life covers either the rental cost or, at its discretion, the cost of purchase.

Diabetic Supplies
The following diabetic supplies are covered in a quantity deemed reasonable by Co-operators Life to the maximum indicated in the schedule of benefits:

- insulin delivery pens
- insulin infusion sets and infusion pump supplies
- syringes
- pen needles
- lancets
- blood test strips

Other diabetic monitoring and administration equipment is reimbursed under Therapeutic Equipment.

Diagnostic Laboratory Expenses
Coverage is provided for diagnostic laboratory and x-ray expenses when coverage is not available under your government health insurance plan; services must be received in your province or territory 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.

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

- crutches, casts, trusses, walkers and canes
- compression garments to treat burns
- graduated compression hose, to the maximum indicated in the schedule of benefits
- food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.
- splints, including shoes attached to a splint. Intra-oral splints are not covered.
- 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 expense under this health care plan.

Therapeutic Equipment
Charges for the rental of, or at Co-operators Life's option, purchase of the medical equipment indicated as covered in the schedule of benefits that is required as a result of a medically diagnosed condition.

Reimbursement for any therapeutic equipment covered will be subject to the co-coverage and lifetime maximum amounts indicated in the schedule of benefits for any one or like piece of equipment.

Oxygen and Equipment
When ordered by a physician in connection with the treatment of a medically diagnosed condition, charges for the provision of oxygen and the equipment needed for its administration are covered.

Orthopedic Shoes and Foot Orthotics

Coverage is provided for custom-made 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 per calendar year is indicated in the schedule of benefits.

Orthopedic Shoes and/or Foot Orthotics must be:

- Prescribed by a Physician or foot Specialist (e.g. podiatrist, chiropractor or chiropodist), and
- Custom-made by an orthotist, pedorthist, podiatrist or chiropodist, and
- Dispensed by an orthotist, pedorthist, podiatrist, chiropractor 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

Coverage is provided for:

- Manual wheelchairs, including reasonable and customary charges for repairs. Special wheelchairs necessary to permit independent participation in daily living are included. Special wheelchair features required primarily for participation in sports are not covered.
- If special wheelchairs are provided in circumstances where the medically diagnosed condition does not warrant a special one, Co-operators Life will provide alternative benefits based on coverage for the type of wheelchair required to permit independent participation in daily living.
- Hospital beds, reasonable and customary charges for the type of hospital bed required for the covered person's medically diagnosed condition. Air-fluidized hospital beds are not covered.

Wigs and Hair Pieces

Coverage is provided for wigs or hairpieces following traumatic surgery or for cancer patients undergoing chemotherapy. The maximum amount payable in a covered person's lifetime is indicated in the schedule of benefits.

Prosthetic Equipment

Reasonable and customary charges for the following prosthetic equipment required for the covered person's medically diagnosed condition are covered to the maximum amount per piece of equipment as indicated in the schedule of benefits:

- artificial limbs, including repairs
- artificial eyes, including rebuilding and polishing of artificial eyes
- external breast prostheses (mastectomy forms) and surgical bras
- prosthetic socks

Reasonable and customary charges for the replacement of an artificial limb or eye are covered once every 10 years if due to attrition or less than 10 years if replacement is required as a result of a physical change in the covered person. Special features required primarily for participation in sports or for cosmetic reasons are not covered.

Communication Aids

The following communication aids are covered:

- Hearing aids, including repairs. Hearing aid batteries, tubing and ear molds provided at the time the hearing aid is purchased are covered. The maximum amount payable is indicated in the schedule of benefits.

Ostomy Supplies
The following colostomy and ileostomy supplies are covered:
- irrigation sets, bags, deodorants, adhesives and skin creams
- charges for catheters, catheterization supplies and urinary kits are also covered

Dental Accident Coverage
Expenses for the repair or replacement of whole, functioning, sound, natural teeth where damage has resulted from an accidental injury which is occasioned solely through violent, external and accidental means (excluding eating accidents or using teeth for purposes for which they are not intended) are covered when:
- the accident occurs while the covered person is covered for this coverage, and
- Treatment starts within 100 days after the accident. This requirement is waived if a diagnosed medical condition delays treatment beyond 100 days.

The charges incurred will not exceed the current dental fee guide for general practitioners in the covered person's province or territory of residence.

Vision Care Benefits
Charges for the purchase of lenses, frames or contact lenses that are required to correct vision when prescribed and dispensed by a licensed optometrist, optician or ophthalmologist.

Charges for laser eye surgery required to correct vision, when prescribed by a licensed optometrist or ophthalmologist and performed by a licensed ophthalmologist. 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.

Northern Medical Transportation Benefit
You will be reimbursed the amount of the deductible applicable to the Basic Provincial or Territorial Medical Plan. The maximum benefit payable as indicated in the schedule of benefits.

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 this plan. Please contact your employer/plan administrator for more details regarding conversion.

Dependent Survivor Benefit
In the event of your death, your dependents will continue to receive these benefits for the duration indicated in the schedule of benefits, provided this health care benefit remains in force and your dependent does not become eligible for benefits under any other group plan as either an employee or dependent and remains an eligible dependent as defined in the plan text.

Extended Health Care General Limitations
No benefits will be paid for:
- Expenses that private insurers are not permitted to cover by law.

- Services or supplies payable by any worker's compensation legislation or similar statute or a third party or where the covered person is entitled to without charge or for which a charge is made only because the covered person has benefits coverage.

- Services or supplies that do not represent reasonable and customary treatment of the covered person's medically diagnosed condition.

- Services or supplies associated with:
  - treatment performed for cosmetic purposes only;
  - recreation or sports rather than with other regular daily living activities;
  - anti-obesity treatment, unless indicated as covered in the schedule of benefits;
  - protein and dietary supplements whether or not prescribed for a medical reason however, food substitutes that can only be administered through a tube feeding process are covered;
  - the diagnosis or treatment of infertility, unless otherwise indicated as covered in the schedule of benefits;
  - contraception, other than drugs

- Services or supplies or expenses:
  - not specifically listed as a covered expense, or
  - associated with covered items, unless specifically listed as a covered expense.

- Services or supplies received outside Canada except as provided under the Emergency Out-of-Canada provision.

- Expenses incurred for:
  - the completion of claim forms,
  - obtaining further medical information regarding claims,
  - medical screening or examinations for the use by a third party, or
  - broken appointments, travel expenses or communication costs

- Expenses arising from:
  - war, insurrection, civil commotion, acts of terrorism or voluntary participation in a riot, or
  - active duty as a member of any branch of the armed forces of any government.

- Extra charges which may result due to any medical practitioner or provider opting-out of the provincial government health insurance plan. Coverage will be provided on the same basis as if the medical practitioner or any other health practitioner was a member of the provincial government health insurance plan.

- Medical care or expenses which are provided or covered by a government health insurance plan, a third party, any worker's compensation legislation or similar statute or a charitable organization, even if the covered person has opted-out of that plan.

- Medical care that was necessitated either wholly or partly, directly or indirectly as the result of committing, attempting or provoking an assault or criminal offence.

- Medical expenses incurred as a result of a situation from injuries sustained in, or directly or indirectly from, a vehicle accident where the covered person was driving a vehicle involved in the accident and had either:
  - alcohol in his or her blood in excess of 80 milligrams of alcohol per hundred millilitres of blood, or
  - his or her ability to operate the vehicle impaired by drugs or alcohol or a combination of the two.

When to submit a claim
Co-operators Life must receive your claim within 12 months from the date the expense was incurred. If the plan text terminates, or the extended health care benefit terminates under your plan, you must submit claims incurred prior to the termination date no later than 90 days after the termination date.

Co-ordination of Extended Health Care Benefits
Co-operators Life will co-ordinate benefits payable under this plan with other plans which also cover you or your dependents for similar benefits. The amount of benefits payable under this plan for allowable expenses incurred during any benefit year will be co-ordinated and/or reduced so that the benefits payable from all plans will not exceed 100% of the actual allowable expenses.

Order of Benefit Payment
If you and your spouse both have family coverage under the group plan where you each work, each of you must first submit your own claims through your own insurer. Any unpaid balance can then be submitted to the other spouse's insurer for payment, along with a copy of the amount already paid by the first benefits plan. Claims for your dependent children should be first submitted through the group plan of the parent with the earlier birthday (month/day) in the calendar year. Any balance is then submitted through the other parent's group plan.

A plan determines its benefits first if it covers the person as an employee:
If the person is covered as an employee under more than one plan, the plans are prioritized in the following order:

- the plan covering the person as an active, full-time employee
- the plan covering the person as an active, part-time employee
- the plan covering the person as a retiree

A plan is secondary if it covers the person as a dependent:
If the covered person is covered as a dependent of more than one person, the plans are prioritized in the following order:

- the plan covering the person as a dependent spouse
- the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year
- the plan covering the person as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday

If the parents are separated or divorced:
The plans under which benefits for the child are determined are prioritized in the following order:

- the plan of the parent with custody of the child
- the plan of the spouse of the parent with custody of the child
- the plan of the parent without custody of the child
- the plan of the spouse of the parent without custody of the child

DENTAL CARE BENEFITS

Coverage administered by Co-operators Life Insurance Company

What am I covered for?

This benefit helps pay the cost of certain dental expenses incurred by you and your covered dependents. To qualify as an allowable expense, the dental treatment must be recommended by a dentist and performed by either a dentist, a dental hygienist under the supervision of a dentist or a licensed denturist operating within the scope of his licence. The dentist, dental hygienist or denturist cannot work with, be related to the covered person or reside in the covered person's home.

Late Dental Application

If you apply for coverage for dental coverage for yourself or your dependents late, benefits will be limited to a maximum of $250 for each covered person for the first 12 months of coverage.

Is pre-determination of certain benefits necessary?

Co-operators Life recommend that for any expenses that are likely to exceed $400, a detailed treatment plan should be submitted before the treatment begins. This procedure will identify the cost you may be responsible for and will provide you with an opportunity to seek an alternative course of treatment, if necessary. In order for benefits to be paid, you must be eligible for coverage on the date the expense is actually incurred.

Dental Fee Guide

The eligible amount is based on the dental fee guide, as indicated in the schedule of benefits, published for the province or territory where the service was rendered. No benefits are payable for any dental treatment where there is no identifiable fee in the fee schedule, or any service designated as a visit fee. For services rendered outside of Canada, for eligible dependent children who are students studying out of Canada or for eligible dental accidents occurring outside of Canada, the fee guide shall mean the current dental association fee guide for general practitioners in your province or territory of residence.

Reasonable Treatment

All services and supplies covered under the Dental Care Benefit provision must represent reasonable treatment. Unless otherwise specified, dental treatment is both described and assessed according to the Canadian Dental Association Uniform System of Coding and List of Services.

Treatment is considered reasonable if it is:

- recognized by the Canadian Dental Association
- performed by a dentist or a dental hygienist under a dentist's supervision where required by the provincial dental association
- and of a form, frequency, and duration essential to the management of the covered person's dental health

Amount Payable

Dental benefits are payable to you unless assigned in writing, to the attending dentist or denturist. Co-operators Life will reimburse you for allowable expenses that are incurred while covered subject to the deductible, co-coverage amounts and benefit maximums indicated in the schedule of benefits. The deductible is the amount you must pay before any benefits become payable under your plan. The co-coverage level is the portion of the expense that is covered under your plan.

X-rays

Co-operators Life reserves the right to request radiographs for the purpose of establishing benefits for multiple extractions to third molars or when numerous restorations are involved. No benefits will be payable for the duplication or interpretation of radiographs.

Laboratory charges
Laboratory charges directly related to covered dental services will be considered at the same level of co-coverage as the covered dental procedure and will not exceed the reasonable and customary amount of the eligible dentist's fee.

Date Expenses are incurred
Allowable expenses are considered to be incurred when treatment is completed. Orthodontic expenses, if covered in the schedule of benefits, are considered to be incurred on a periodic basis throughout the course of treatment.

Alternate Benefit Clause
Where there are two or more courses of eligible treatment available to adequately correct a dental condition, reimbursement may be based on the cost of the least expensive treatment that provides the covered person with adequate care. Professional dental concepts of treatment and dental plan liabilities are not necessarily the same. The alternate benefit clause is in no way an attempt to change a treatment plan. The choice of treatment is a matter for agreement solely between the patient and the dentist.

Covered Dental Care Services

Level 1 – Basic Preventative and Restorative Covered Services:

- Exams are limited to 2 recalls as indicated in the schedule of benefits and 1 exam, other than a recall or complete oral examination, every 12 months.
- A complete dental examination is covered once per lifetime with any one particular dentist or once in a 36 month period if the dentist is changed.
- Full mouth or complete series x-rays are covered once in a 24 month period. Full mouth series of radiographs and panoramic films are considered the same for the purpose of this plan. Either, but not both, will be allowed once in a 24 month period.
- Cavity revealing bitewing x-rays are covered as indicated in the schedule of benefits.
- Cleaning of the teeth is covered as indicated in the schedule of benefits. Two time units of polishing are covered during the recall exam period indicated in the schedule of benefits.
- Fluoride application to the teeth is covered as indicated in the schedule of benefits.
- Procedures for the extraction of teeth and their roots, including pre and post-operative care. No benefits are payable for any additional charge for the removal of sutures in connection with any dental treatment.
- Non-bonded amalgam (silver) and tooth coloured fillings on both front and back teeth for restoring the natural tooth surfaces, including retentive pins. Stainless steel crowns for the restoration of dependent children's teeth are also covered. If bonded amalgams are performed, expenses will be limited to the cost of non-bonded amalgams.
- Simple space maintainers, for children under 19, for keeping the space of a lost baby tooth until the permanent tooth comes in.
- Denture repairs, resetting and relining of removable denture teeth, once every 36 months per arch. Addition of teeth to a denture is covered provided the additional teeth are required to replace teeth that were lost, extracted or fractured after the effective date of the covered person's coverage under this plan. Denture cleaning and polishing charges are not covered.
- Filing the surfaces (edges) of the teeth (interproximal discing).

- Pit and fissure sealants are covered as indicated in the schedule of benefits.
- Caries and pain control procedures are covered only when performed on a day separate from any other restorative procedure.
- Desensitization of teeth and pulp mummification will not be covered as a separate procedure code.
- 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.
- Repairs to existing gold restorations.

Level 2 – Minor Restorative Endodontic and Periodontic Services:

1. **Endodontics** – treatment of the pulp chamber and pulp canal.
   - Standard root canal therapy for permanent and primary teeth limited to one course of treatment per tooth. Repeat treatment is covered only if the original therapy fails after the first 24 months and has not been reimbursed by Co-operators Life. If retreatment is payable, it will be considered as if it were initial treatment.
     - opening through a crown is not covered in conjunction with endodontic therapy
     - no benefits will be paid for enlargement of pulp chambers or endosseous intra coronal implants
     - extra charges for difficult access, exceptional anatomy and calcified canals are not covered

2. **Periodontics -** treatment of the soft tissue (gums).
   - Scaling, root planing and occlusal adjustment and equilibration are covered as indicated in the schedule of benefits.
   - 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.
   - Periodontal appliance coverage must be approved by Co-operators Life dental consultant.

Level 3 – Major Restorative Covered Services:
All expenses under this level must be pre-determined.

Crowns, inlays and onlays are covered when a tooth has extensive structural loss due to traumatic injury, fracture of the tooth or cusps, or where there have been very large areas of filling combined with decay that prevent the use of more traditional filling materials such as silver amalgam and plastics to adequately restore the tooth.

Crowns, Inlays and Onlays and related items:

- The initial provision of crowns, inlays or onlays. Coverage for tooth coloured crown/abutments, inlays or onlays on molars is limited to the cost of metal applications only.
- Temporary stainless steel crowns for an adult must fulfil the same criteria as a regular crown to be a covered benefit. The cost of a stainless steel crown will be deducted from the cost of a permanent crown.
- Veneers, composite or porcelain, whether lab processed or not, must be referred to the dental consultant for approval.
- Posts, cores, pins and copings related to covered crowns.

- Repairs to covered tooth-coloured materials.
- Removal and recementation of crowns, inlays and onlays.

Replacement of existing crowns, inlays and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable.

No benefits will be paid for:
- crowns needed due to wear (attrition) and cosmetic reasons
- covering of a tooth with a crown in order to prevent possible future damage to the tooth
- extra lab charges for a crown made to fit an existing partial denture clasp

Dentures, Bridgework and Implants:
The following appliances are covered when required to replace one or more teeth, at least one of which was extracted while the covered person was covered for major coverage under this plan.
- initial installation of standard complete dentures or overdentures
- standard cast or acrylic partial removable dentures or fixed bridgework
- tooth implantation and surgical insertion of fabricated implants

Coverage for tooth-coloured retainers and pontics on molars are limited to the cost of metal retainers and pontics.

Replacement appliances are also covered when:
- The existing appliance is temporary - the amount reimbursed for the temporary appliance will be deducted from the cost of the permanent appliance.
- The existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the covered person is covered for major coverage under this plan as a result of:
  - the placement of an initial opposing appliance, or
  - the extraction of additional teeth. If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth

No benefits will be paid for:
- services or supplies for equilibration of dentures, or denture cleaning or polishing
- replacement of dentures which are mislaid, lost or stolen (denture repairs are covered under basic services)
- 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

Level 4 – Orthodontic Covered Services:
Benefits are payable for Orthodontic services performed for covered persons as indicated in the schedule of benefits. Treatment must begin after the effective date of the covered person's coverage under this plan.

Orthodontic Treatment
Charges incurred for fixed and removable appliances used in the correction of malocclusion caused by dental irregularities are covered. This includes related charges for observations, adjustments, repairs, alterations, removal and retention. Simple space maintainers are covered under basic services.

***Orthodontic Treatment Plan*:**
For each course of orthodontic treatment, a treatment plan is required. The orthodontist must submit a treatment plan to Co-operators Life before treatment begins.

Payment of Orthodontic Services
Co-operators Life is unable to prepay orthodontic services. If the covered person chooses to pay the orthodontist in advance, Co-operators Life will reimburse incurred expenses as follows:

- the initial payment will be 1/3rd of the total paid to the orthodontist
- the remaining balance of the covered expense will be reimbursed monthly based on the estimated length of treatment as indicated by the orthodontist. It is your responsibility to submit the monthly amount paid with a completed dental claim form and a copy of the original paid in full receipt. Completion of Part 1 by the dentist is not required.
- lost, mislaid or stolen orthodontic appliances will not be replaced

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 this plan. Please contact your employer/plan administrator for more details regarding conversion.

Dependent Survivor Benefit
In the event of your death, your dependents will continue to receive these benefits for the duration indicated in the schedule of benefits, provided this dental care benefit remains in force and your dependent does not become eligible for benefits under any other group plan as either an employee or dependent and remains an eligible dependent as defined in the plan text.

Dental Care General Limitations
No Dental Benefits will be paid for:

- services or supplies not specifically listed as covered
- services or supplies that do not represent reasonable treatment
- procedures, appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or vertical wear
- expenses that private insurers are not permitted to cover by law
- any additional charges for the removal of sutures in connection with any dental treatment
- charges for anaesthesia unless in conjunction with oral or periodontal surgery
- services or supplies payable by any worker's compensation legislation or similar statute or third party or where the covered person is entitled to without charge or for which a charge is made only because the covered person has benefits coverage
- Services or supplies associated with:
  - ⇨ treatment performed for cosmetic purposes only
  - ⇨ congenital defects or developmental malformations or replacement of congenitally missing teeth

- ⇨ temporomandibular joint disorders
- ⇨ bacteriological tests or smears unless submitted with a letter of expertise from the dentist explaining the treatment

- Miscellaneous services:
  - ⇨ nutritional counselling or dental plaque control
  - ⇨ oral hygiene instruction, unless covered in the schedule of benefits
  - ⇨ treatment planning
  - ⇨ completion of claim forms or pre-determinations
  - ⇨ consultations, other than with specialists
  - ⇨ travel expenses, broken appointments or communication costs

When to submit a Dental claim

Co-operators Life must receive your claim within 12 months from the date the expense was incurred. If the plan text terminates, or the dental care benefit terminates under your plan, you must submit claims incurred prior to the termination date no later than 90 days after the termination date.

Benefits after termination for dental work in progress

No benefits are payable for dental expenses incurred after the date the covered person's coverage terminates under this plan if benefits should be paid by the replacing dental plan even if a detailed treatment plan was filed and benefits were determined by Co-operators Life prior to the termination date.

Where there is no replacing dental coverage Co-operators Life will extend coverage for work in progress as follows:

- 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 in the 3 months prior to termination of coverage, dental expenses in connection with these procedures incurred within 30 days of termination will be considered as incurred prior to termination.

- where orthodontic treatment has commenced and a treatment plan has been submitted in advance and approved by Co-operators Life, dental expenses in connection with the dental treatment incurred within 90 days of termination will be considered as incurred prior to termination. This extension of benefits does not apply in the case where orthodontic coverage has terminated only because your child has attained the age indicated in the schedule of benefits.

Co-ordination of Dental Care Benefits

Co-operators Life will co-ordinate benefits payable under this plan with other plans which also cover you or your dependents for similar benefits. The amount of benefits payable under this plan for allowable expenses incurred during any benefit year will be co-ordinated and/or reduced so that the benefits payable from all plans will not exceed 100% of the actual allowable expenses.

Order of Benefit Payment

If you and your spouse both have family coverage under the group plan where you each work, each of you must first submit your own claims through your own insurer. Any unpaid balance can then be submitted to the other spouse's insurer for payment, along with a copy of the amount already paid by the first benefits plan. Claims for your dependent children should be first submitted through the group plan of the parent with the earlier birthday (month/day) in the calendar year. Any balance is then submitted through the other parent's group plan.

A plan determines its benefits first if it covers the person as an employee:
If the person is covered as an employee under more than one plan, the plans are prioritized in the following order:

- the plan covering the person as an active, full-time employee
- the plan covering the person as an active, part-time employee
- the plan covering the person as a retiree

A plan is secondary if it covers the person as a dependent:
If the covered person is covered as a dependent of more than one person, the plans are prioritized in the following order:

- the plan covering the person as a dependent spouse
- the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year
- the plan covering the person as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday

If the parents are separated or divorced:
The plans under which benefits for the child are determined are prioritized in the following order:

- the plan of the parent with custody of the child
- the plan of the spouse of the parent with custody of the child
- the plan of the parent without custody of the child
- the plan of the spouse of the parent without custody of the child

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.

Co-operators 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.

Co-operators 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 Co-operators systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Co-operators commitment to security is emphasized in Co-operators Code of Ethics and extends to the contracts and agreements that Co-operators 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. Co-operators do not share your medical information without your express consent.

You have the right to access your personal information. Send Co-operators your requests in writing and ask Co-operators Life 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
Email: privacy@cooperators.ca