Saskatoon Board of Education
Group Benefits Plan
Group 6013
Non-Teaching Staff

the co-operators
A Better Place For You®

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Your Group Benefits Plan

Group Benefit Plan
Group 6013
Non-Teaching Staff
Effective: April 1, 2015
Issued: March 18, 2015

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

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YOUR GROUP INSURANCE PROGRAM

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

Who is eligible to enroll?
All employees who are actively at work, and are under the age of 65, will be eligible the 1st day of the month after completing 90 days of continuous service. For Extended Health Care and Dental Benefits, employees must work a minimum of 15 hours per week.

How do I apply?
By completing an application form provided by The Co-operators or a group enrollment card provided by your employer, within one month of becoming eligible. Late applications may require evidence of good health prior to coverage becoming effective.

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

❖ Note: You are responsible for advising your Human Resources Department of any change in dependent status.

Who is a dependent?
Your spouse or common-law spouse (provided the common-law spouse has resided with you for a minimum of 12 months).

Your unmarried dependent children who are not working full-time:

- from birth to attainment of their 21st birthday, or
- up to attainment of their 25th birthday who are in full-time attendance at any accredited educational institute, or
- of any age who are suffering from a permanent mental or physical infirmity and are wholly financially dependent upon you and residing with you and who became disabled while otherwise eligible under either of the above two.

  *No person will be considered a dependent if they reside outside of Canada on a permanent or temporary basis.

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

Your dependents' coverage terminates when your coverage terminates or when the dependent no longer is a dependent.

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

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

- prior to the expiration of 60 days after the claim form has been filed in accordance with the requirements of the master Policy; or
- unless brought:
    - where no benefits have been paid, within one year from the expiration of the time within which the claim form is first required by the Policy or from the date on which Co-operators Life first denies the claim for benefits, whichever first occurs; or
    - where benefits have been paid under the provision of the Policy, within 1 year of the date on which Co-operators Life terminates the payment of benefits.

The time limit within which to commence an action shall expire on the date(s) as specifically provided for in this provision and in no event shall it be extended to each and every monthly payment accruing after the date(s).

Accessing your records
As required by legislation, for insured benefits, if you reside in a province where legislation requires that you have the right to obtain a copy of your enrollment form or application for insurance and any written statements or other record not otherwise part of the application that you provided to Co-operators Life as evidence of insurability.

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

How do I submit a claim?
Claim forms are available from your employer or from our website www.cooperators.ca and click on Group >Group Benefits.

Extended Health Care Claims
Extended health care claim forms must be completed by you and your employer (if applicable) 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 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 Dental treatment plans for pre-determination may be submitted electronically if your dental office has the capability to submit claims online. If your dental office does not accept online transmission please submit a completed standard Dental Association claim form.

Prescription Drug Claims for Pay-direct Drug Card Plans
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.

Claim forms can be mailed to:
Group Claims Department
The Co-operators
1920 College Avenue
REGINA, Saskatchewan
S4P 1C4

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

Is pre-determination of certain benefits necessary?
We recommend that for extended health care or dental expenses 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.

Conversion Privilege
On termination of your group life insurance prior to age 65, you and/or your spouse may obtain an individual policy with The Co-operators Life Insurance Company without providing evidence of good health on a Permanent Traditional Plan, a Term to age 65 Plan, or a One Year non-renewable Term Plan at The Co-operator's regular rates.

This individual policy will be limited to the lesser of $200,000 or the difference between the amount of insurance at the time of your termination and the amount of insurance for which you are eligible under a new group contract, at the time you are exercising your right to convert.

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

Your life insurance will continue during the 31 day conversion period whether or not you apply for conversion.

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. 6013 issued by the Co-operators Life Insurance Company to the Policyholder/Plan Sponsor Saskatoon Board of Education 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 Policyholder funds the Extended Health Care Plan. This means that the Policyholder has the sole legal and financial liability for benefits and funds the claims. Co-operators Life is only the administrator of the Extended Health Care Plan. The Extended Health Care 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.

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.

BASIC GROUP LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

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

Each employee under 65 years of age	2 times your salary to a maximum benefit of $350,000 rounded to the next highest $1,000 if not already a multiple thereof.
Each employee 65 years of age or older	$5,000

If you become eligible for an increase in salary that exceeds 15% in a 12 month period, you may be required to submit health evidence prior to receiving an increased amount of insurance. You are required to submit a written application on forms provided by The Co-operators and the increased amount of insurance will not take effect until the application has been approved in writing by Co-operators Life.

Your salary is your regular annual earnings paid by your Employer, exclusive of bonuses and overtime earnings, commissions will be averaged over the previous 36 months.

Living Assistance Benefit

The living assistance benefit is available as an advance payment of your Basic Life Insurance to help meet the medical or other health and welfare expenses of terminally ill employees under age 65.

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

The amount of money available as a living benefit payment is 50% of your Basic Life Insurance benefit, to a maximum of $50,000.

Total Disability Waiver of Premium

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

Submitting a Claim

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

Termination Age

Your basic group life insurance coverage terminates at age 70.

DEPENDENTS INSURANCE

Insurance provided by Co-operators Life Insurance Company

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

Spouse.....$10,000

Child (over 14 days) $5,000

Child (0 - 14 days).....$500

Total Disability Waiver of Premium

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

Termination Age

Your dependents insurance terminates when you reach age 70.

OPTIONAL GROUP LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

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

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

Each employee &/or eligible spouse	Units of $10,000 to a maximum of $250,000

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

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

Termination Age
Your optional group life insurance coverage terminates at age 70.

"Covered Loss" means a Critical Disease, Accidental Death, Accidental Dismemberment and Disease Dismemberment covered under this Provision. The Covered Loss must occur prior to your 65th birthday for Critical Disease or your 70th birthday for other Covered Losses, and while you are insured for this benefit. In the case of a Covered Loss, which qualifies under the accidental death and dismemberment benefit, the Covered Loss must occur within 365 days after the date of the injury.

Critical Disease Benefit
The Co-operators will pay you an amount equal to 10% of your basic life insurance amount to a maximum of $50,000, provided you have been diagnosed with a critical disease prior to age 65 and while insured under this benefit and have been totally disabled from that disease and have not been able to work at any occupation for at least 9 months. Benefits are limited to the first covered critical disease in your lifetime.

"Critical Disease" shall mean any one of the following diseases diagnosed after the effective date of your coverage; Poliomyelitis, Parkinson's Disease, Huntington's Chorea, Multiple Sclerosis, Alzheimer's Disease, Type I Diabetes (Insulin Dependent), Amyotrophic Lateral Sclerosis (ALS), Peripheral Vascular Disease, and Necrotizing Fasciitis.

Accidental Death Benefit
If Co-operators Life is furnished with proof that your death occurs as a direct result of accidental bodily injuries occasioned solely through external, violent and accidental means without negligence on your part, Co-operators Life will pay an amount equal to 100% of the basic life insurance amount to your beneficiary.

Accidental/Disease Dismemberment Benefit
If Co-operators Life is furnished with proof that you sustained one of the following losses, as a direct result of a critical disease or resulting directly and independently of all other causes from bodily injuries occasioned solely through external, violent and accidental means, without negligence on your part, Co-operators Life will pay:

Loss of:	**Amount:**
Total paraplegia (total paralysis of both lower limbs), or hemiplegia (total paralysis of one side of the body), or quadriplegia (total paralysis of all four limbs).	200% of your basic group life insurance benefits.
Both hands or both feet, or sight of both eyes, or one hand and one foot, or use of both hands, or use of both arms, or use of both legs, or use of one hand or arm and one leg, or sight of one eye and one hand or one foot.	100% of your basic group life insurance benefit.
One hand, or one foot, or one arm, or one leg, or sight of one eye, or use of one hand, or use of one arm, or use of one leg.	50% of your basic group life insurance benefit.
The thumb and index finger of the same hand, or loss of speech, or loss of hearing in both ears.	33 1/3% of your basic group life insurance benefit.

Rehabilitation Benefit
In the event that you sustain a covered loss and the loss requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such covered loss, Co-operators Life will pay the reasonable and necessary expenses actually incurred for the services of a licensed rehabilitation provider, within 2 years from the date of the covered loss.

Payment by Co-operators Life for the total of all expenses incurred will not exceed $10,000 as the result of any one covered loss. Payment does not include incidental expenses including without limitation charges for room and board, ordinary living, travelling or clothing expenses.

Family Transportation Benefit
If you sustain a covered loss and are confined as an inpatient in a hospital located at least 150 kilometres from your residence and are under the regular care and attendance of a physician or surgeon, Co-operators Life will pay the reasonable expenses actually incurred by all members of your immediate family for hotel accommodation in the vicinity of the hospital and transportation by the most direct route to your location.

This benefit will not exceed the aggregate amount of $3,000 for all accommodation and transportation expenses. Payment will not be made for incidental expenses including without limitation charges for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.30 per kilometre travelled.

Home Alteration and Vehicle Modification Benefit
If you sustain a covered loss and subsequently require the use of a wheelchair to be ambulatory, Co-operators Life will pay the reasonable and necessary expenses incurred for the purpose of making your home and vehicle wheelchair accessible.

Benefits are payable for the cost of alterations to your principal residence and the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required.

The expenses must be incurred within 2 years from the date of the covered loss and are subject to a maximum of $10,000 in your lifetime.

Continuation of Education Benefit
In the event that your death occurs as a direct result of a covered loss under this benefit, Co-operators Life will pay to your beneficiary the education benefit stated below for each of your dependent children who are, at the time of your death enrolled as full-time students:

(1) in an institution for higher learning above the secondary school level as defined in the province, territory or country of residence; or
(2) at the secondary school level but who will enroll as full-time students in an institution for higher learning within 365 days after your date of death.

The education benefit is equal to the reasonable and necessary expenses actually incurred for tuition and books, subject to the lesser of a maximum of 5% of your basic life insurance amount or $5,000, for each year the dependent child continues the education, but not to exceed 4 years, which must run consecutively, with respect to any one dependent child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled as a full-time student in an institution for higher learning, but payment will not be made for expenses incurred prior to your death, or for incidental expenses including without limitation room, board or other ordinary living, travelling or clothing expenses.

If none of your dependent children satisfy the above requirements, Co-operators Life will pay an amount of $2,500 to your beneficiary.

Spousal Occupational Training Benefit
In the event that your death occurs as a direct result of a covered loss under this benefit, Co-operators Life will pay the reasonable and necessary expenses actually incurred for tuition and books for your spouse to participate in a formal occupational training program to become qualified for active employment in an occupation for which your spouse would not otherwise have sufficient qualification.

Expenses must be incurred within 2 years from the date of your death and are subject to a maximum lifetime payment of $10,000. Payment will not include incidental expenses including without limitation charges for room and board, ordinary living, travelling or clothing expenses.

Repatriation Benefit
In the event that your death occurs (due to any cause) out of Canada, or if in Canada at least 150 kilometres outside your normal place of residence, Co-operators Life will pay, to your beneficiary, the reasonable and customary expenses incurred for the preparation of your body and its transportation to the funeral home or the place of interment in proximity to your normal place of residence in Canada. Benefits will not exceed $10,000 for all eligible expenses.

Maximum Benefit
In no case shall an amount greater than the basic life insurance amount be paid for all covered losses sustained by you resulting directly or indirectly from the same accident or critical disease with the exception of paraplegia, hemiplegia and quadriplegia where the benefit payable is 200% of the amount of basic life insurance.

Definitions
Loss of hand shall mean severance at or above the wrist.

Loss of a leg shall mean severance at or above the knee joint.

Loss of an arm shall mean severance at or above the elbow joint.

Loss of foot shall mean severance at or above the ankle.

Loss of a toe shall mean complete severance of two entire phalanges of the toe.

Loss of thumb shall mean complete loss of one entire phalanx of the thumb.

Loss of index finger shall mean the complete loss of two entire phalanges of the index finger.

Loss of sight, loss of hearing or loss of speech shall mean total and irrecoverable loss of that faculty. If that faculty can be recovered or partially recovered by the use of some device or rehabilitative program, it shall be deemed that there was no loss for the purposes of this provision.

Loss of use must be caused by tendon, nerve or bone damage. Such loss of use must be total and irrecoverable and must be continuous for a period of 12 months after which any benefit is payable, provided such disability is determined to be permanent.

Paralysis shall mean complete and irreversible paralysis caused by brain, spine, muscle or nerve damage as a result of an accident or covered critical disease which has continued for a period of 12 months from the date of the accident or diagnosis of critical disease, after which any benefit is payable under this benefit.

Institution for higher learning for the education benefit, includes any university, college or trade school.

Hospital, for the family transportation benefit, means an institution licensed as a hospital, open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with 24 hour nursing services. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

Regular care and attendance, for the family transportation benefit, means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

Immediate family, for the family transportation benefit, means a person who is your spouse, son, daughter, father, mother, brother or sister. Other relatives may be considered in the event that no "immediate family" are living.

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

Exclusions
No benefits will be paid if your covered loss is caused by or results directly or indirectly from one or more of the following:

- suicide or attempted suicide or self-inflicted injury, while sane or insane, or
- committing, attempting or provoking an assault or criminal offense, or
- a situation where the Covered Loss results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving the 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 capacity impaired as a result of drug or alcohol usage, or
- disease (other than the covered Critical Diseases), or bodily or mental infirmity, or medical or surgical treatment of any kind, except surgical reattachment, or
- death where there is no visible contusion on the exterior of the body (except death by drowning), or
- any drug, poison, gas or fumes, voluntarily or otherwise taken administered, absorbed or inhaled, other than as a result of an occupational accident, or
- insurrection or war (whether war be declared or not) or participation in any riot, or active service in the armed forces of any country, or
- travel or flight in any aircraft, or descent from such aircraft, if you are a pilot or a member of the crew of the aircraft, or if such flight is made for the purpose of instruction, training or testing.

Termination Age
Your accidental death, disease and dismemberment benefit terminates at age 70.

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

Insurance provided by Co-operators Life Insurance Company

In addition to your basic accidental death and dismemberment insurance you may apply to become insured for an additional amount of accidental death and dismemberment benefit, by completing the application form provided by The Co-operators. If your application is approved, coverage will take effect on the first day of the next month. You may elect to be covered by either of the following plans.

Plan I Employee Only Plan

You may select any amount of benefit in units of $10,000 to a maximum of $350,000.

Plan II Family Plan

You may select any amount of benefit in units of $10,000 to a maximum of $350,000 and your family will be insured for the following:

i) **Spouse**

Your spouse will be insured for either 50% of the benefit if you have dependent children or 60% of the benefit if you do not have dependent children.

ii) **Children**

Each dependent child will be insured for either 15% of the benefit if there is a spouse or 20% of the benefit if there is no spouse.

If death, dismemberment, loss of sight or hearing is caused by an accident prior to age 70 and occurs within 365 days of the accident, payment will be made as follows:

Loss of:	**Amount:**
Total paralysis of both lower limbs, or total paralysis of one side of body, or total paralysis of all four limbs.	200% of the benefit for which you have been approved.
Life, or both hands or both feet, or sight of both eyes, or one hand and one foot, or sight of one eye and either one hand or one foot, or use of both arms, or use of both hands.	100% of the benefit for which you have been approved.
One arm or one leg or loss of use of one arm or one leg.	75% of the benefit for which you have. been approved
One hand or one foot or loss of use of one hand or one foot, or loss of sight of one eye, or loss of hearing in both ears.	66.6% of the benefit for which you have been approved.
The thumb and index finger of the same hand, or loss of four fingers of one hand.	33.3% of the benefit for which you have been approved.
Hearing in one ear.	16.7% of the benefit for which you have been approved.

All toes on one foot.	12.5% of the benefit for which you have been approved.

Limitation
If one accident results in more than one of the losses above, payment will not exceed 200% of the optional accidental death and dismemberment benefit.

Repatriation Benefit
In the event accidental loss of life occurs outside the province of residence (due to any cause) and indemnity for such loss becomes payable in accordance with the terms of this policy, the insurer will pay the reasonable and customary expenses incurred for the transportation of the body of the deceased insured person to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased, including charges for the preparation of the body for such transportation, not to exceed in the aggregate the amount of $10,000 for all such expenses.

Rehabilitation Benefit
In the event an insured person sustains an injury which results in a loss payable under the policy, and such injury requires that the insured person participate in a rehabilitation program in order to be qualified to engage in an occupation in which the insured person would not have engaged except for such injury, the insurer will pay the reasonable and necessary expenses actually incurred, within 2 years from the date of the accident, by the insured person.

Payment by the insurer for the total of all expenses incurred by any insured person will not exceed $10,000 as the result of any one accident. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Special Education Benefit
If you select the family plan and you die in an accident, your dependent children will be eligible to receive 5% of your optional benefit (to a maximum of $5,000) if they are enrolled, on the date of the accident, as a full-time student in any institution of higher learning beyond the secondary school level. Any dependent child who is enrolled as a full-time student at the secondary school level on the date of the accident and subsequently enrolls within 365 days of the accident, as a full time student in an institution of higher learning will also be eligible for this benefit.

This benefit will be payable annually, for a maximum of four consecutive annual payments, but only so long as the dependent child continues full-time post secondary education.

In the event accidental loss of life is sustained by an insured person and indemnity for such loss becomes payable in accordance with the terms of the policy, the insurer will pay the reasonable and necessary expenses actually incurred within 20 months from the date of the accident, by the spouse of the insured person who engages in a formal professional or trades training program in which the spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, not to exceed in the aggregate the amount of $5,000 for all such expenses. Payment will not be made for room board or other ordinary living, travelling or clothing expenses.

Family Transportation Benefit
When, following an injury which results in a loss payable under the policy, an insured person is confined as an inpatient in a hospital located from a point of not less than 200 kilometres from the insured person's normal place of residence and such insured person is under the regular care and attendance of a legally qualified physician or surgeon, other than himself or herself, the insurer will pay the reasonable expense actually incurred by all members of the immediate family of the insured person for hotel accommodations in the vicinity of the hospital and transportation by the most direct route to the confined insured person, not to exceed in the aggregate the amount of $10,000 for all such expenses. Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.30 per kilometre travelled.

"Hospital" means an institution licensed as a hospital, open at all times for the care and treatment of injured persons, with organized facilities for diagnosis, major surgery and with 24 hour nursing services. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home or convalescent hospital.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

"Immediate Family" means a person who is the spouse, son, daughter, father, mother, brother or sister of the insured person. Other relatives may be considered in the event that no "immediate family" are living.

Loss Due to Disappearance
If your body has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which you were an occupant, then it shall be deemed that you shall have suffered loss of life.

Common Disaster
If you select the family plan and an accident results in your death and the death of your spouse (within 90 days of the accident), the optional benefit for your spouse will be increased to an amount equal to the optional benefit for yourself.

Seat Belt Benefit
Benefits under the Optional Accidental Death and Dismemberment benefit will be increased by 10% if the covered person's injury or death results while the person is a passenger or driver of a private passenger type automobile and the seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Exclusions
No Optional Accidental Death and Dismemberment Benefits will be paid if the Covered Loss is caused by or results directly or indirectly from one or more of the following:

- suicide or attempted suicide or self-inflicted injury, while sane or insane, or
- committing, attempting or provoking an assault or criminal offense, or
- a situation where the Covered Loss results from injuries sustained in, or directly or indirectly from, a vehicle accident where you were driving the 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 capacity impaired as a result of drug or alcohol usage, or

- disease (other than the covered Critical Diseases), or bodily or mental infirmity, or medical or surgical treatment of any kind, except surgical reattachment, or
- death where there is no visible contusion on the exterior of the body (except death by drowning), or
- any drug, poison, gas or fumes, voluntarily or otherwise taken administered, absorbed or inhaled, other than as a result of an occupational accident, or
- insurrection or war (whether war be declared or not) or participation in any riot, or active service in the armed forces of any country, or
- travel or flight in any aircraft, or descent from such aircraft, if you are a pilot or a member of the crew of the aircraft, or if such flight is made for the purpose of instruction, training or testing.

Total Disability Waiver of Premium

Should you become totally disabled prior to age 65, and you are eligible for long term disability benefits, the amount of your accidental death and dismemberment coverage will continue without payment of premiums until age 65 or recovery, as long as this benefit and your employer's coverage under this benefit remains in force, providing satisfactory proof of total disability is submitted to Co-operators Life within 12 months from the date of disability.

Termination Age

Your optional accidental death and dismemberment benefit terminates at age 70.

LONG TERM DISABILITY

Insurance provided by Co-operators Life Insurance Company

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

Your taxable benefit is determined as follows:

Each employee	67% of your monthly salary to a maximum monthly benefit of $6,000 or 85% of your pre-disability gross salary, whichever is less.

Your salary is your regular monthly earnings paid by your Employer, exclusive of bonuses and overtime earnings, commissions will be averaged over the previous 36 months.

If you become eligible for an increase in salary that exceeds 15% in a 12 month period, you may be required to submit health evidence prior to receiving an increased amount of insurance. You are required to submit a written application on forms provided by The Co-operators and the increased amount of insurance will not take effect until the application has been approved in writing by The Co-operators.

Benefits will commence on the 106th day of continuous/consecutive disability.

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

In no case shall a benefit be paid beyond:

- the date of your 65th birthday, or
- the date you are no longer totally disabled, or
- retirement or the date you withdraw or elect to receive pension funds, or
- the date you engage in any work or occupation other than rehabilitative employment, or
- the date you fail to furnish satisfactory evidence of total disability or refuse to submit to a medical examination by a physician chosen by The Co-operators, or
- the date you refuse to participate in any rehabilitation program approved by The Co-operators,

whichever occurs first.

Successive periods of disability arising from the same or related cause and separated by less than six months will be treated as one period of continuous total disability.

Benefit Adjustment

At the time of a claim, your long term disability benefit will be reduced by any disability benefits you are entitled to receive from any worker's compensation act or similar statute, Canada/Quebec Pension Plan, any criminal injuries compensation legislation and any automobile insurance act. The reduction will also include any CPP/QPP retirement benefits; however, will not include any additional amounts payable for dependents or cost of living increases.

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

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

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

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

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

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

You will be required to reimburse The Co-operators for benefits received in accordance with the terms and conditions stated in the reimbursement agreement.

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

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

Exclusions
a. No benefit will be payable for any disability resulting from or caused by:

- intentionally self-inflicted injury, while sane or insane, or
- insurrection, war or hostilities of any kind, or
- riot or civil commotion regardless of whether you were participating, or
- injury occurring while committing or attempting to commit a criminal offense including without limitation driving a vehicle with alcohol in the blood in excess of 80 milligrams of alcohol per 100 milliliters of blood. A "vehicle" means, a vehicle that is drawn, propelled or driven by any means other than muscular power, or

- medical or surgical care which is cosmetic in nature or medical care or surgery that is not medically necessary. However, periods of disability due to the donation of an organ or tissue will be covered, or

- use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment from a rehabilitation centre or an institution provincially recognized for that treatment, or

- injury or sickness for which a third party is liable, except as provided for in the third party liability section.

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

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

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

Submitting a Claim
The time limit within which a long term disability claim must be made is 90 days from the date The Co-operators is liable.

Termination Age
Your long term disability coverage terminates at age 65.

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

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

Co-coverage
The Co-operators will pay 70% of the covered charges.

Coverage Maximum
The maximum reimbursement per calendar year is unlimited except as defined under the benefits section.

Benefits
The plan covers the following:

Home Nursing Care
Home nursing care is covered if:
- it starts while the covered person is insured under this Extended Health Care Benefit, 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.

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

Pre-determination of Home Nursing Care Benefits
A pre-determination of benefits is an assessment provided by Co-operators Life that identifies:
- the type of nurse that will be covered;
- the number of hours to be covered per day or week; and
- the estimated duration of coverage.

To receive a pre-determination of benefits, 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 reserves the right to request additional information at the time of claim and in relation to an ongoing claim.

These benefits are supplemental to any services the Covered Person is entitled to under their provincial home care plan. The Covered Person should apply for benefits through their provincial home care plan before applying for benefits under the plan.

Home Nursing Care Benefit

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

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

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

Coverage is limited to the minimum number of hours and level of skill needed to provide each essential nursing service. Applicable licensing restrictions will be 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 per calendar year is $10,000.

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" shall mean 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.

Practitioners

Charges for the services of the following practitioners, when treating sickness or injury, are covered to the maximum benefit of $500 per person in any calendar year for each service: osteopath, chiropractors, podiatrists, naturopaths, physiotherapists, psychologists/social workers, speech therapists, massage therapists, audiologists and acupuncturist.

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

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

Optometrist/Ophthalmologist Services

Charges for eye examinations by an optometrist or ophthalmologist, provided no part of the cost is covered by the government health insurance plan, is limited to 1 examination in a 24 month period for adults and 1 examination in a 12 month period for dependents under 18.

Ambulance Services
Charges for ambulance service, including where medically necessary, the fare of one attendant.

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

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

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

Prescription Drugs
All prescription drug expenses will be covered by the way of a pay-direct drug card plan.

Co-operators Life will cover the Expenses for the following drugs required to treat a medically diagnosed condition that are listed in the Saskatchewan Health Drug Formulary:

(i) Drugs that are prescribed, including some over the counter drugs if listed in the provincial formulary, from a Physician, Dentist or other health care provider legally licensed to order specified drugs within their province of jurisdiction according to:
   - the Food and Drugs Act, Canada, and
   - provincial legislation in effect where the drug is dispensed.

Prescription Drugs 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.
- proprietary or patent medicines registered under the Food and Drugs Act, Canada.
- 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.
- 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 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, health foods, most vitamins, homeopathic, naturopathic or herbal drugs, lozenges, dental products and mouthwashes.
- drugs prescribed for the treatment of erectile dysfunction, infertility or obesity whether or not prescribed for a medical reason.
- drugs which would have been payable by the provincial plan if proper application had been made.

Provincial Drug Plans
Covered expenses for drugs included in the regular benefits section as eligible under any provincial drug plan are limited to any deductible and co-coverage amounts you are required to pay for yourself and any eligible dependents.

Prescription Drugs Benefit Maximums
The maximum amount payable for products used to quit smoking that require a prescription by law is $100 per lifetime. The maximum amount payable for all other prescription drug expenses in a calendar year is unlimited.

Diabetic Supplies
The following diabetic supplies are covered to a maximum of $1,000 per year per person:

- 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.

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 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 a maximum of 2 pair per year.
- 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 extended health care expense.

Therapeutic Equipment
Charges for the rental of, or at Co-operators Life's option, purchase of the following medical equipment required as a result of a medically diagnosed condition:

- diabetic administration equipment (insulin infusion pumps)
- diabetic blood glucose monitoring equipment (BGM machines)
- intermittent positive pressure breathing machine (IPPB)
- continuous positive airway pressure machine (CPAP)
- 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
- suction pumps

Reimbursement for any therapeutic equipment covered will be subject to 70% co-coverage and the lifetime maximum for any covered person will be $1,000 for any one or like piece of therapeutic 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 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 $300.

Orthopedic shoes and/or foot orthotics must be:

- prescribed by a physician or foot specialist (e.g. podiatrist or chiropodist), and
- custom-made and dispensed by an orthotist, pedorthist, podiatrist or chiropodist.

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

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

Wheelchairs and Hospital Beds

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.
- Standard Hospital Beds. Electric and Air-fluidized hospital beds are not covered.

Prosthetic Equipment

Charges for the following standard prosthetic equipment are covered:

- Artificial limbs, including repairs.
- Artificial eyes, including rebuilding and polishing of artificial eyes.
- External breast prostheses (mastectomy forms) once every 60 months and 2 surgical bras per year.
- Prosthetic socks are covered to a maximum of 5 pair per year.

Charges for the replacement of an artificial limb or eye are covered when the replacement is required as a result of a physical change in the covered person.

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

Hearing Aids
Charges for the cost of, installation and repairs (excluding batteries or routine maintenance) of a hearing aid(s) purchased on the written recommendation of an audiologist, subject to a maximum benefit of $750 in any 60 months.

Ostomy Supplies
Charges for essential ostomy supplies including irrigating sets, bags, deodorants, pads, adhesives or skin creams. Charges for catheters and urinary kits are also covered.

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

Speech Aids
Charges for bliss boards and laryngeal speaking aids, when no alternative method of communication is possible. The maximum amount is $1,000 per lifetime per covered person.

Vision Care
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.

This coverage is not subject to the cash deductible or any co-coverage provision.

Charges for laser eye surgery required to correct vision, to a maximum of double the vision care benefit, once in a covered person's lifetime, when prescribed by a licensed optometrist or ophthalmologist and performed by a licensed ophthalmologist.

The following limitations and exclusions shall apply:

The maximum reimbursement shall be $250 in any 24 consecutive months per covered person. The "date dispensed" is used to determine payment of this benefit.

Limitation and Exclusions
The plan does not cover charges incurred for, caused by or contributed to by:

- medical examination for the use of a third party, or
- obtaining further medical information regarding claims for covered expenses or any expenses incurred for the completion of claim forms, or
- a physician or other health practitioner for travel, broken appointments or communication costs, or
- charges which are not permitted by law/legislation for The Co-operators to cover. Any changes to provincial legislation or the government health insurance plan will not automatically result in a change of coverage provided under the plan, or

- cosmetic surgery, services or treatment which are not necessary for treatment of a sickness or injury, or
- the failure of any covered person to make claim for and receive benefits within the time and in the manner prescribed under or pursuant to the government health insurance plan to which they are entitled. If a covered person is not a member of a government health insurance plan by reason of having opted-out or for any other reason is not a member of a government health insurance plan the employee will be deemed, for the purposes of the plan, to be a member of the government health insurance plan, or
- extra charges which may result due to the physician opting-out of the government health insurance plan, or
- bodily injury resulting directly or indirectly from war or act of war, insurrection, riot, hostilities of any kind or when a covered person is a member of the armed forces of any government, or
- any criminal offense, or
- suicide or attempted suicide, or
- charges in excess of what is reasonable & customary in your province of residence, or
- expenses for which no charge would ordinarily be made if there were no insurance coverage, or
- the renovation or alteration in any physical way to a covered person's residence, vehicles or place of business, including the filtration or purification, whether mechanical or electronic, of air, water or other environmental factors, or
- the repair or alteration of any prosthetic device incurred after the initial placement and fitting or charges incurred due to the replacement of any prosthetic device unless the replacement is due to a change in the covered person's physical condition, or
- anti-obesity treatment including drugs, proteins and dietary or food supplements whether or not prescribed for a medical reason, or
- private or semi-private room charges in an acute care hospital where the type of care is primarily custodial care or while awaiting admission to a custodial care facility, or
- the purchase of a myoelectric controlled prosthetic. However, The Co-operators will pay an amount equal to the reasonable and customary charges of non-myoelectric prosthetic device, or
- charges for any method of contraception other than oral contraception, or
- any benefit otherwise payable under the plan will be reduced by any amount the covered person received or is eligible to receive from:
    - the government health insurance plan,
    - any worker's compensation act or similar statute,
    - any government hospital, medical, dental or health care plan, whether payable or not.

  Where the 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. Benefits will be payable as stated under this plan once an amount equal to the grant has been spent on the covered expenses for which the grant was intended.

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

- charges for experimental medical procedures or treatment not approved by the Canadian Medical Association or the appropriate medical specialty society, or
- charges not specified in the list of covered eligible medical expenses, or
- charges for any services or supplies associated with recreation or sports.

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

Co-ordination of Benefits
If you have coverage under more than one plan, benefits will be co-ordinated so that the amount payable will not exceed 100% of the actual allowable expenses. A plan determines its benefits first if it covers the person as an employee.

If that person is covered as an employee under more than one plan, the plans are prioritized in the following order:

1. the plan covering the person as an active, full-time employee;
2. the plan covering the person as an active, part-time employee;
3. the plan covering the person as a retiree;

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

1. the plan covering the person as a dependent spouse;
2. the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year;
3. 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:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

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

Termination Age
Your extended health care benefits terminate at age 70.

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

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

Coverage Maximums
Benefits will not exceed the current schedule of fees for general practitioners as determined by the College of Dental Surgeons in the province in which you reside. For Residents of Alberta, "Fee Guide" shall mean the 1997 Alberta Dental Association fee guide, plus an inflationary adjustment as determined by The Co-operators.

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

Plan A - Basic services: unlimited per year
Plan B - Major restorative services: $2,000 per year
Plan C - Orthodontic services: $2,000 per lifetime benefit

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

Plan A - Basic Services
The plan will cover 70% of the following eligible charges:

- Exams are limited to 1 recall each 6 months and 1 exam, other than a recall or complete oral examination, every 12 months.
- A complete dental examination is covered once with any one particular dentist or once in a 36 month period if the dentist is changed, provided the plan has not paid for any other examination during the past 6 months.
- Full mouth or complete series x-rays 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.
- Two cavity revealing bitewing x-rays are covered once in a 6 month period.
- Cleaning of the teeth (up to and including 2 time units of polishing) once every 6 months.
- Fluoride application to the teeth of children up to the age of 21, once every 6 months.
- Tooth extractions.
- Dental surgery procedures.
- Anaesthesia is covered only if related to covered surgical procedures.
- Fillings, both silver amalgam and tooth-coloured plastic resins.
- Treatment for the relief of dental pain.

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

- Relining, rebasing, and repairing of removable dentures to a maximum of $400 per calendar year.
- Root canal therapy (endodontics).
- Treatment of the gums (periodontics).
- Stainless steel crowns for the repair of children's teeth.
- Interproximal discing

Plan A - Exclusions and Limitations

- ⇨ Full mouth series of radiographs and panoramic films are considered the same for the purpose of the plan. Either, but not both, will be allowed once in a 24 month period.
- ⇨ Co-operators Life reserves the right to alter the benefits payable where multiple restorative services are performed at a single appointment in one quadrant of the mouth. In such a case, where the time value for a service is decreased, it may be assumed that the relative value units (RVU) for the service or services will also be reduced.
- ⇨ Pit and fissure sealants are covered for dependent children under 14 years of age.
- ⇨ Co-operators Life reserves the right to request radiographs for the purpose of establishing benefits for multiple extractions to third molars. Co-operators Life also reserves the right to request radiographs in order to establish benefits for multiple composite restorations in upper or lower anterior teeth or where numerous restorations are involved.
- ⇨ Canal enlargement will not be covered as a separate procedure.
- ⇨ Desensitization of teeth and pulp mummification will not be covered as a separate procedure.
- ⇨ Caries and pain control procedures will only be covered when performed on a day separate from any other restorative procedure.
- ⇨ Periodontal scaling, root planing and occlusal equilibration are limited to 8 units for each service per calendar year.
- ⇨ Periodontal surgery is limited to 4 sites per calendar year with one surgical procedure per site. Reasonable and Customary expenses are payable for anaesthetic when required in conjunction with covered periodontal or oral surgery. Any charges for facility fees or other related expenses are not covered.
- ⇨ All requests for periodontal appliance coverage must be referred to the dental consultant before being approved.
- ⇨ Opening through a crown is not payable in conjunction with endodontic therapy.

Plan B - Major Restorative Services

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

- ⇨ The initial provision of crowns or onlays. Coverage for tooth coloured crown/abutments or onlays on molars is limited to the cost of metal applications only.
- ⇨ Replacement of existing crowns and onlays after a period of 5 years since placement of the restoration and if the restoration is no longer serviceable.

- ⇨ initial installation of full dentures, partial removable dentures, fixed bridgework or tooth implants and surgical insertion of fabricated implants, if required to replace one or more natural teeth, at least one of which has been extracted after the effective date of the insured individual's coverage under the plan, and

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

- ⇨ Addition of teeth to existing dentures. Addition of teeth to existing fixed bridgework, if required to replace the natural tooth/teeth extracted after the effective date of the insured individual's coverage under the plan, and

- ⇨ Adjustments to a new partial or complete denture would be covered after the denture has been worn for at least 3 months.

- ⇨ Tooth implantation and surgical insertion of fabricated implants, if required to replace the natural tooth/teeth extracted after the effective date of the insured individual's coverage under the plan, and

- ⇨ All veneers, composite, porcelain or composite restorations, whether lab processed or not.

Plan B - Exclusions and Limitations

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

- ⇨ Crowns needed due to wear (attrition) and cosmetic reasons are not covered. Covering of a tooth with a crown in order to prevent possible future damage to the tooth is not covered.

- ⇨ Denture cleaning and polishing is not covered.

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

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

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

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

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

- ⇨ No benefit will be payable for the initial installation (or addition) of bridgework unless such installation (or addition) is required primarily due to teeth that were lost, extracted or fractured (so that removal was necessitated) after the effective date for such bridgework under the plan, and

- ⇨ All expenses covered under this section should be pre-determined.

Plan C - Orthodontic Services

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

- ⇨ Charges incurred for treatment, services and appliances used in the correction of malocclusion caused by dental irregularities.

Plan C - Exclusions and Limitations

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

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

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

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

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

- ⇨ Lost or stolen orthodontic appliances will not be replaced.

General Limitations and Exclusions

No amount shall be payable under this benefit for charges:

- incurred as a result of self inflicted injury, or
- which are excluded under any general limitations for health coverage, or
- incurred as a result of any dental disease, defect or injury arising out of or in the course of an insured individual's employment, unless otherwise specifically stated in the plan schedule, or
- for procedures, appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or vertical wear or to restore occlusion or to treat, in any form, problems of the temporomandibular joint, or
- for services which would not normally have been made but for the presence of this coverage or for which the employee or dependent is not legally obligated to pay or for which dental care is provided or may be provided to a covered person without cost or at a nominal cost by public authorities or under a government medical plan or accidents or diseases covered by any worker's compensation act or similar statute, or
- for dental treatment not approved by the Canadian Dental Association or which is experimental in nature, or

- for dental care deemed to be cosmetic in nature, including bleaching of endodontically treated teeth or with respect to congenital malformations or for the replacement of congenitally missing or supernumerary teeth, or
- for services or supplies which were necessitated either wholly or partly, directly or indirectly as the result of committing, attempting or provoking an assault or criminal offence or by a war or act of war (whether declared or not) insurrection or riot or hostilities of any kind, or
- for miscellaneous services such as for counselling or instruction, treatment planning, filling out of claim forms or predeterminations, consultations other than with specialists, travel, broken appointments or communication costs, or
- for any dental examinations required by a third party, or
- for services or fees which do not fulfil, within the criteria of dental practice in the province in which the claimant resides, of usual and customary treatment or fees, or
- for any additional charges for the removal of sutures in connection with any dental treatment.
- for charges for anaesthesia unless in conjunction with oral or periodontal surgery.
- for or in connection with orthodontic treatments, including correction of malocclusion, unless such treatment is specifically included in the plan, or
- for bacteriological tests or smears unless submitted with a letter of expertise from the dentist explaining the treatment, or
- for diagnostic casts unless required for orthodontic treatment.

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

Co-ordination of Benefits
If you have coverage under more than one plan, benefits will be co-ordinated so that the amount payable will not exceed 100% of the actual allowable expenses. A plan determines its benefits first if it covers the person as an employee.

If that person is covered as an employee under more than one plan, the plans are prioritized in the following order:

1. the plan covering the person as an active, full-time employee;
2. the plan covering the person as an active, part-time employee;
3. the plan covering the person as a retiree;

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

1. the plan covering the person as a dependent spouse;
2. the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year;
3. 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:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

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

- 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.

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

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

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

Termination Age
Your dental coverage terminates at age 70.

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.

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

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

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

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

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

Co-operators Life Insurance Company
Attention: Group Insurance Department - Privacy
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Regina, Saskatchewan
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