Associum Group Benefits Insurance Program

ASSOCIUM Benefits - Basic
Group Number G. 6312
Account 30000
All Employees

the co-operators
A Better Place For You®

the co-operators®
A Better Place For You®

Your Group Benefits Plan

ASSOCIUM Benefits - Basic
Group Number G. 6312
Account 30000
All Employees
Effective: January 1, 2018
Issued: April 12, 2018

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

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INTRODUCTION

WELCOME TO YOUR GROUP INSURANCE PLAN

We are pleased to provide you with a comprehensive package of group insurance 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.

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, 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.

Your Plan Administrator is:
Associum Consultants
1 Concorde Gate, Suite 802
Toronto, ON M3C 3N6
1(416) 867-9350

ASSOCIUM

This booklet is meant to provide general information about your group benefit plan. It is not a legal contract. The master Policy G. 6312 issued by Co-operators Life Insurance Company to A.C. Johnson & Associates Inc. o/a ASSOCIUM BENEFITS determines the benefits, amounts and effective dates that apply to you and 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, the terms and conditions of the Policy prevail.

Your employer reserves the right to amend, modify, qualify, reduce, suspend or terminate any of the benefits provided under the master group policy and/or plan 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.

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

EXTENDED HEALTH CARE BENEFITS

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

Deductible:

- for Hospital expenses per year.....no coverage
- for Emergency Out of Canada and Travel Benefits Plus per year.....$0
- for Out of Canada Referral Benefit $0
- for Prescription Drug expenses per year.....$0
- for Vision Care expenses per year.....no coverage
- for All Other Extended Health Care expenses per year:
  - ⇨ Employee $0
  - ⇨ Employee with Dependents.....$0

Premier Drug Plan:

- Pay-Direct Card Plan
- generic drug equivalent (lowest cost interchangeable drug) unless Physician specifies no substitution
- Pharmacy dispensing fees exceeding the Reasonable and Customary amount per prescription are not covered (not applicable to Quebec residents)

Prescription Drug coverage for Quebec residents – the maximum benefit payable per Covered Person for each 12 months of coverage shall be unlimited. The maximum out-of-pocket contribution per covered adult is determined by the RAMQ drug plan including any maximum co-payment, co-insurance or deductible amounts. Expenses for Dependent Children will be applied to the Employee's out-of-pocket amount. Only drugs eligible under the RAMQ drug plan are applied to the out-of-pocket maximum. After the Covered Person has reached the out-of pocket maximum amount we will reimburse drugs eligible under the RAMQ drug plan at 100% co-insurance. All other prescription drugs will continue to be reimbursed at the group drug plan co-insurance amount.

The benefits provided under this plan to any Covered Person who is a resident of a Province that offers a public prescription drug plan will be administered in accordance with the requirements of the applicable prescription drug insurance legislation and will meet any applicable minimum coverage standard.

Schedule of Benefits

Co-Insurance:

- for Hospital expenses.....no coverage
- for Emergency Out of Canada expenses and Travel Benefits Plus 100%
- for Out of Canada Referral Benefit 50%
- for Vision Care expenses.....no coverage
- for Therapeutic Equipment..... 75%
- for Prescription Drugs 75%
- for all other Extended Health Care expenses..... 75%

Maximums per Covered Person:

- Emergency Out of Canada lifetime maximum $5,000,000
- Out of Canada Referral Benefit lifetime maximum $15,000
- Prescription Drugs calendar year maximum $3,000
  Quebec residents – drug maximum will not apply to drugs listed on the RAMQ basic drug plan formulary
- Extended Health Care calendar year maximum .....unlimited
- Travel Benefits Plus is included

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

Extended Health Care Benefit Maximums:

- for hospital accommodation .....no coverage
- for Convalescent Hospital .....no coverage
- for home nursing care.....$5,000 per year
- for paramedical practitioners:
  - ⇨ Acupuncturist.....$300 per year
  - ⇨ Audiologist.....$300 per year
  - ⇨ Chiropractor .....$300 per year
  - ⇨ Massage Therapist.....$300 per year
  - ⇨ Naturopath/Homeopath.....$300 per year
  - ⇨ Nutritionist/Dietitian .....$300 per year
  - ⇨ Occupational Therapist .....$300 per year
  - ⇨ Osteopath .....$300 per year
  - ⇨ Physiotherapist.....$300 per year
  - ⇨ Podiatrist/Chiropodist .....$300 per year
  - ⇨ Psychologist/Social Worker.....$300 per year
  - ⇨ Speech Therapist.....$300 per year
- for Eye Examinations:
  - ⇨ for Adults .....one exam per 24 months
  - ⇨ for Dependent Children.....one exam per 12 months
- for Vision Care Prescription eye-wear .....no coverage
- for Diabetic Supplies .....unlimited
- for custom-made Orthopedic Shoes and.....$300 per year
  custom-made Orthotics combined

- for diagnostic laboratory expenses ..... $500 per year
- for anti-smoking aids (Quebec) ..... annual maximum as determined by RAMQ
- for prescription anti-smoking aids (other residents) ..... $100 per lifetime
- for anti-obesity drugs ..... no coverage
- for fertility drugs (Quebec residents) ..... covered in accordance with the RAMQ drug plan
- for fertility drugs (residents of all other Provinces) ..... no coverage
- for sexual dysfunction drugs ..... no coverage
- for hearing aids ..... $500 per 5 years
- for speech aids ..... $1,000 per lifetime
- for Therapeutic Equipment ..... $5,000 per piece of equipment per lifetime

  (diabetic administration equipment (insulin infusion pumps), diabetic blood glucose monitoring equipment (BGM machines), breathing machines and equipment (such as IPPB/APAP/CPAP/BiPAP or any other type of breathing machines or equipment), 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 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) ..... 2 per 24 months
- for surgical brassieres ..... 2 per year
- for graduated compression hose ..... 2 pair per year

Survivor Benefit for Dependents: ..... 24 months

Termination age: ..... Employee's 75th birthday

Schedule of Benefits

DENTAL CARE BENEFITS

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

Calendar Year Deductible:

- Employee $0
- Employee with Dependents $0

Co-insurance Levels:

- Level 1 ..... *Basic Restorative Services* 75%
- Level 2 ..... *Endodontic & Periodontic Services* 75%
- Level 3 ..... *Major Restorative Services* ..... no coverage
- Level 4 ..... *Orthodontic Services* ..... no coverage

Dental Care Benefit Maximums:

- Level 1 ..... *Basic Restorative Services* ..... } $1,000 combined
- Level 2 ..... *Endodontic & Periodontic Services* ..... } maximum per year
- Level 3 ..... *Major Restorative Services* ..... no coverage
- Level 4 ..... *Orthodontic Services* ..... no coverage

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

Other Dental Care Information:

- ⇨ Recall exams (and bitewings and cleanings) once every 9 months.
- ⇨ Fluoride treatment for Children up to the age of 21 only.
- ⇨ Oral hygiene instruction is not a covered expense.
- ⇨ 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: ..... 24 months

Termination age: ..... Employee's 75th 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 when you join the plan, and
- have been employed for 3 consecutive months.

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 insurance, 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 (under age 26 if a resident of Quebec) 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 and your spouse is residing with you, insured under your plan and has custody of the child.
- A child for whom you or your spouse has been appointed guardian is not an eligible dependent unless we have received satisfactory proof of guardianship. If your insured 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.

General Information

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 insurance 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.

Any person age 65 or over insured under the RAMQ drug plan may have elected to waive health care coverage under this plan or the prior plan, however, once such election is made it is irrevocable and the option to become insured for health care under this plan at a later date is not available.

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 insurance that is more than the amount available without evidence of insurability,
- you apply for coverage you previously declined.

For residents of Quebec, the health evidence requirement will be waived for the purpose of extended health care coverage (including drugs).

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 we approve your application.

If you were not actively at work on the date your insurance would normally become effective or increase, then that insurance 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 we approve the application.

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. This does not apply to Quebec residents for drug coverage.

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

General Information

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

If you live in Quebec, and you name your spouse as your beneficiary, it is irrevocable unless you stipulate otherwise, in writing on the beneficiary form. Any other beneficiary that you name is revocable unless otherwise stipulated.

If you live in any other province, you have the right to name a beneficiary at the time you apply for insurance 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 insurance take effect?
Increase in insurance:
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 we approve your application.

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

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)
- 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 up to 90 days if requested by your employer on a basis that does not discriminate against another employee and as long as premiums continue to be paid
- the end of a period for which premiums have been paid for your insurance
- the date you cease to be in a class of employees eligible for insurance
- the date you reach the termination age specified in the schedule of benefits under each benefit, except if you reside in Quebec where drug coverage will continue if you are working, or
- the date your employer's group policy or plan terminates

  Note: if you live in Quebec and cease to be actively at work as a result of a strike, work stoppage or lock-out, your drug coverage will be extended for 30 days and premiums must be paid.

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 have been paid for dependent coverage

The Claims Process

Where do I find a claim form?
Extended Health and dental claim forms can be found on the MDM website at www.mdm-insurance.com.

For Health and Dental benefits:
MDM Insurance Services Inc.
P.O. Box 970 Guelph, ON N1H 6N1
Phone number: 1-800-838-1531 or 1-519-837-1531
Fax number: 1-519-836-4909
Email: inquiry@mdm-insurance.com

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 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.

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.

General Information

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 MDM Insurance Services Inc.

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 provisions. You must provide information required to prove your entitlement to benefits and must also authorize us to obtain information from other sources for this purpose (if required). From time to time, we will ask you to provide us with proof of your total disability. Whenever we request information or authorization, 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.

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.

General Information

After completion, Extended Health Care and Dental Care claim forms should be sent to:

MDM Insurance Services Inc.
P.O. Box 970 Guelph, ON N1H 6N1
Phone number: 1-800-838-1531 or 1-519-837-1531
Fax number: 1-519-836-4909
Email: inquiry@mdm-insurance.com

Third Party Liability

If you and/or your insured dependent become totally disabled due to an injury or sickness or become eligible for reimbursement of insured 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.

EXTENDED HEALTH CARE BENEFITS

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

Is pre-determination of certain benefits necessary?
We 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 insured 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-insurance Levels and Deductible Amounts
Allowable expenses are reimbursed at the co-insurance level indicated in the schedule of benefits. Extended health care benefits are subject to any maximums identified for the covered services or supplies.

Extended Health Care Benefits

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-insurance 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 insured 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.

Home Nursing Care
Home nursing care is covered if:
- it starts while the covered person is insured 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. We 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

Extended Health Care Benefits

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 insured
- 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

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 medical emergency or
- the loss is a covered medical emergency that occurred within the covered persons province of residence at a location in excess of 500 kilometres from the covered person's home

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

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

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

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

- Bedside Attendance - reimbursement for round-trip economy airfare by the most direct route via a common carrier in the event that the covered person becomes hospitalized as a result of a covered injury or sickness, if the attending physician advises that the covered person requires the attendance of a family member or close friend.

- Return of Vehicle – reimbursement of the reasonable and customary amount to a maximum of $3,000 for a commercial agency to return a vehicle to the covered person's home or, if a rental vehicle was used, to the nearest rental agency, in the event that the covered person is unable, for reasons of a covered illness or injury, to return home with the vehicle used for the journey, or:

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

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

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

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

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 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.

Out of Canada Referral Benefit
Referral out of Canada for medical treatment which is available in Canada, up to the out of Canada Referral Benefit co-insurance and maximum amounts indicated in the schedule of benefits.

If, while outside Canada on referral for medical treatment, you or your dependent requires treatment for a medical condition which is related directly or indirectly to the referral treatment, the total expenses payable for all treatment are subject to the Out of Canada Referral maximums shown in the schedule of benefits. These charges are also subject to the Out of Canada maximum shown in the schedule of benefits.

For all medical care given out of Canada, other than emergency medical treatment Co-operators Life requires:

- that it be recommended as medically necessary by a Physician practicing in Canada, and
- that a detailed treatment plan be submitted with cost estimates before treatment begins.

Co-operators Life will then advise the Employee of any benefit that will be provided.

Charges for the following are eligible:

- Physicians services;
- hospital room and board at standard ward rates. Charges in excess of ward rates are payable if this benefit plan covers hospital services in Canada. In such case, the amount payable under this expense is subject to the hospital accommodation and maximum shown in the schedule of benefits;
- the cost of hospital services;
- hospital charges for outpatient treatment;
- licensed ambulance services, including air ambulance to transfer the patient to the nearest medical facility or hospital where adequate medical treatment is available; and
- medical evacuation for admission to an Approved Hospital in the Province in Canada where the patient normally resides

Covered Expenses will be limited to reasonable and customary charges less the amount payable by the government health insurance plan, or which would have been payable had proper application been made.

All other charges incurred while outside the Province of residence are payable under the appropriate covered expense on the same basis as if they were incurred in the covered person's province of residence.

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 of residence, subject to the deductible and co-insurance amounts indicated in the schedule of benefits.

To be eligible for reimbursement, the paramedical practitioner must be registered and licensed to practice in the province 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.

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 that require a prescription 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

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; and
- they are considered a life sustaining drug, for example: insulin, nitroglycerin for immediate release.

Extended Health Care Benefits

For residents of Quebec, in addition to the prescription drug coverage described in this section, benefits are also provided for eligible drugs listed on the current RAMQ basic drug plan formulary.

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.
- 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. 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 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.

Extended Health Care Benefits

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-insurance amounts the covered person is required to pay. For residents of Quebec, this will not apply to eligible drugs listed on the current RAMQ basic drug plan formulary.

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 tests and x-ray expenses (including ultrasounds, PET and CT scans, and MRI examinations), when ordered by a Physician and received in the Covered Person's Province of residence in a facility licensed to perform such tests and services. The maximum amount payable per Covered Person per year is indicated in the Schedule of Benefits. No benefits will be payable for services 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-insurance 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 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.

Extended Health Care Benefits

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
Charges for the following standard prosthetic equipment are covered to the maximum amount per piece of equipment payable 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

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.

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.
- Speech aids, such as bliss boards and laryngeal speaking aids, when no alternative method of communication is possible. The maximum amount payable in a covered person's lifetime 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 insured 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 of residence.

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, without payment of premiums, 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 policy.

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 insurance 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
We must receive your claim within 12 months from the date the expense was incurred. If the policy 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
What if I have comparable coverage under my spouse's plan?
If you are insured 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.

We 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 insurance 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

What am I insured for?
This benefit helps pay the cost of certain dental expenses incurred by you and your insured 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 insurance for yourself or your dependents late, benefits will be limited to a maximum of $250 for each insured person for the first 12 months of coverage.

Is pre-determination of certain benefits necessary?
We 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 the employee's province 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. We will reimburse you for allowable expenses that are incurred while insured subject to the deductible, co-insurance 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-insurance 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-insurance 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 1 recall 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.
- Two 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.

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 us. 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 our dental consultant.

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, without payment of premiums, 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 policy.

Dental Care Benefits

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 insurance 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
- 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

We must receive your claim within 12 months from the date the expense was incurred. If the policy 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 insurance 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 us prior to the termination date.

Where there is no replacing dental insurance we 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 insurance, 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 us, 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

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

If you are insured 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.

We 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 insurance 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

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
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