



Group 6822 Account 001
Full-Time
SK Bargaining Unit Employees



Your Group Benefits Plan

ISM Information Systems Management
Canada Corporation (ISM Canada)
Group 6822 Account 001
Full-Time SK Bargaining Unit Employees
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For more information visit www.cooperators.ca and click on *Group >Group Benefits*

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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 Co-operators Life Insurance Company. Your group insurance plan provides valuable security. This booklet describes in summary your employee benefit plan as of the date shown on the cover.

The purpose of this booklet

The purpose of this booklet is to summarize the main provisions of the master group policy, for your general guidance. If there are any discrepancies or omissions found in this booklet, the provisions of the master policy (available from your employer or plan administrator) will apply as the final basis for the settlement of all claims. You are encouraged to read this booklet carefully so that you may fully understand the benefits available to you and your dependents.

Important note

Possession of this booklet alone does not mean that you or your dependents are automatically insured. The applicable group policy must be in effect and all of the requirements of the policy must be satisfied.

As this booklet contains information that is important to you, you are encouraged to read it thoroughly and discuss any questions you have with your employer or plan administrator. Please file this booklet in a safe place with your other important documents for future reference.

To avoid delays, always include your full name and personal identification number (i.e. certificate number), your employer name and your group policy number on any claim forms or correspondence submitted to Co-operators Life.

Changing your records

To ensure that coverage is kept up to date for you and your dependents, it is vital that you advise your plan administrator of any changes. This includes a name change, change in marital status or dependents, change of beneficiary, or application for benefits previously waived. Changes reported more than 31 days after the date of change may require health evidence of insurability.

Your Plan Administrator

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/deposits, reporting all new enrolments, terminations, changes etc. 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.

Introduction

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 G. 6822 and/or the Plan Text G. 6822 issued by Co-operators Life Insurance Company to ISM Information Systems Management Canada Corporation (ISM Canada) shall be the final basis for the settlement of all claims. Where there is a discrepancy or conflict between the description in this booklet and the Policy or the Plan Text, the terms and conditions of the Policy and the Plan Text prevail.

Co-operators Life is only the administrator of the Extended Health Care, Vision Care and Dental Care Plans. It has no liability whatsoever to Employees and/or other Covered Persons including any liability for benefits provided under the Extended Health Care, Vision Care or Dental Care Plans. These Plans are self-funded. This means that the Plan Sponsor, ISM Information Systems Management Canada Corporation (ISM Canada), is responsible for all of the obligations to the Employees and/or other covered Persons including the payment of all benefits under the Extended Health Care, Vision Care and Dental Care Plans.

Schedule of Benefits

SCHEDULE OF BENEFITS

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

BASIC LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

Benefit Formula:	300% of annual Salary, rounded to the next highest \$1,000 if not already a multiple thereof.
Amount of Insurance:	The amount calculated using the benefit formula. The maximum amount of insurance is: Non-Evidence Maximum: \$750,000 Health Evidence Maximum: \$1,000,000 At age 65, the amount of insurance reduces by 50%.
Termination age:	Employee's 70 th birthday
Total Disability Life Waiver:	Premiums for this benefit are waived after a 119 day period of Total Disability, retroactively to the date of disability. The definition of Total Disability for the Basic Life Waiver matches the definition of Total Disability for the Long Term Disability Benefit defined in the Policy. Waiver of premium terminates at age 65.

DEPENDENT LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

Amount of Insurance:	\$10,000 Spouse amount \$3,000 Child amount (from Birth)
Termination age:	Employee's 70 th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

OPTIONAL LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

Amount of Insurance:	An Employee may select any amount of insurance from a minimum of \$10,000 to a maximum of \$250,000 in units of \$10,000.
Termination age:	70 th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

Schedule of Benefits

DEPENDENT OPTIONAL LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

Amount of Insurance:	A Spouse may select any amount of insurance from a minimum of \$10,000 to a maximum of \$250,000 in units of \$10,000.
Termination age:	70 th birthday
Total Disability Waiver of Premium:	When Basic Life Insurance premiums are waived.

PAID-UP INSURANCE

Insurance provided by Co-operators Life Insurance Company

Amount of Insurance:	Flat \$5,000 per Employee.
Termination age:	death
Total Disability Waiver of Premium:	no coverage

LONG TERM DISABILITY BENEFITS

Insurance provided by Co-operators Life Insurance Company

Benefit Formula:	60% of monthly Salary, rounded to the next highest \$1 if not already a multiple thereof.
Monthly Benefit:	The amount calculated using the benefit formula. The maximum Monthly Benefit is the lesser of \$15,000 or the amount calculated using the formula for the All Source Maximum. Non-Evidence Maximum: \$8,500 Health Evidence Maximum: \$15,000
All Source Maximum:	100% of pre-disability Net Salary
Occupational Coverage:	yes, 24-hour coverage
Elimination Period:	- for accidental Injury 119 consecutive Days - for Sickness 119 consecutive Days
Own Occupation Period:	The Elimination Period and the next 24 months thereafter Any and All
Benefit Duration:	to age 65

Schedule of Benefits

Recurrent Total Disability:	- 6 months for Employees not engaged in a Rehabilitation Program. - 12 months for Employees engaged in a Rehabilitation Program.
COLA:	the CPI increase but not exceeding 5%, after 1 year of Total Disability
Tax Status:	Non-taxable
CPP Offset:	Primary
Termination age:	Employee's 65 th birthday
Total Disability Waiver of Premium:	Premiums are waived when Long Term Disability benefits are eligible to be made. Waiver of premium terminates at age 65.

EXTENDED HEALTH CARE BENEFITS

Coverage administered by Co-operators Life Insurance Company

Calendar Year Deductible:

- for Hospital expenses.....none
- for Prescription Drug expenses.....none
- for Emergency Out of Canadanone
- for Vision Care expensesnone
- for all other Extended Health Care expenses.....none

Premier Drug Formulary:

- Pay-Direct Drug Card
- Co-payment per prescription0%
- Generic and brand name drugs

Co-Coverage Level:

- for Hospital expenses.....100%
- for Emergency Out of Canada expenses100%
- for out-of-Canada Referral 80%
- for Vision Care expenses100%
- for Pay-Direct Card expenses100%
- for Therapeutic Equipment100%
- for all other Extended Health Care expenses.....100%

Maximums per Covered Person:

- Emergency Out of Canada maximum per Injury or Sickness\$1,000,000
- Out-of-Canada Referral\$50,000
- Extended Health Care calendar year maximumunlimited

Maximum Out of Country duration90 days

Schedule of Benefits

Extended Health Care Benefit Maximums:

- for hospital accommodation semi-private room
- for Convalescent Hospital 180 Days
- for home nursing care \$5,000 per year
- for paramedical practitioners:
 - ⇒ Reflexologist } \$900 combined
 - ⇒ Osteopath } maximum per year
 - ⇒ Physiotherapist } \$900 per year
 - ⇒ Chiropractor } \$900 per year
 - ⇒ Massage Therapist..... } \$900 per year
 - ⇒ Podiatrist } \$300 per year
 - ⇒ Psychologist } \$300 per year
 - ⇒ Speech Therapist } \$300 per year
 - ⇒ Acupuncturist } \$1,200 combined
 - ⇒ Naturopath..... } maximum per year
 - ⇒ Homeopath }

The services of a Physiotherapist, Psychologist or Speech Therapist may require written certification that the services are medically necessary.

- for Eye Examinations:
 - ⇒ for Adults 1 exam per 24 months
 - ⇒ for Dependent Children 1 exam per 12 months
(under 18 years of age)
- for Vision Care Prescription eye-wear:
 - ⇒ for Employees \$750 per 24 months
 - ⇒ for Spouses & Dependent Children \$500 per 24 months
(under 18 years of age)
 - ⇒ The maximum amount in the case of a covered person who requires non-elective contact lenses shall be the greater of \$750 or the cost of one pair of contact lenses within the 24 month period for Employees or the greater of \$500 or the cost of one pair of contact lenses within the 24 month period for Spouses & Dependent Children.
 - ⇒ laser eye surgery benefit \$1,500 per lifetime
- for Diabetic Supplies unlimited
- for custom Orthopaedic Shoes \$200 per year
- for Special Foot Orthotics..... one pair per year to a maximum of \$300
- for prescription anti-smoking aids \$200 per lifetime
- fertility drugs \$5,000 per lifetime
- for hearing aids \$500 per lifetime

Schedule of Benefits

- for Therapeutic Equipment unlimited
 - ⇒ diabetic blood glucose monitoring equipment (BGM machines).
 - ⇒ 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.

- for prosthetic limbs and artificial eyes unlimited
- support stockings unlimited
- for hair pieces following surgery or treatment \$500 per lifetime
- for external breast prosthesis (mastectomy forms) once per 5 years
- for surgical brassieres 2 per year

Survivor Benefit for Dependents: 1 year

Termination age: 70

Extension of Benefits for Total Disability:

If you are Totally Disabled on the date coverage under the Plan Text would otherwise terminate, provided the Plan Text and the Extended Health Care benefits under this Plan remain in force, your coverage will remain in effect while Totally Disabled as a result of the same sickness or injury. The Insurance Company will pay the eligible expenses resulting from your sickness or injury, which incurred within 12 months immediately following the date coverage under the Plan Text should have terminated.

DENTAL CARE BENEFITS

Coverage administered by Co-operators Life Insurance Company

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

Calendar Year Deductible: none

Co-coverage Levels:

- Level 1 *Basic Restorative Services* 100%
- Level 2 *Endodontic & Periodontic Services* 100%
- Level 3 *Major Restorative Services* 80%
- Level 4 *Orthodontic Services* 50%

Schedule of Benefits

Dental Care Benefit Maximums:

- Level 1*Basic Restorative Services* } \$2,500
- Level 2*Endodontic & Periodontic Services* } combined
- Level 3*Major Restorative Services* } \$1,500 per year
- Level 4*Orthodontic Services* } \$5,000 lifetime

Dental Fee Guide for General Practitioners: Current year

Other Dental Care Information:

- Recall exams (and fluoride and cleanings) once every 6 months
- Bitewings 4 every 6 months
- Fluoride treatment for Children and adults..... once every 6 months
- A complete dental examination once in any 24 month period
- Full mouth or complete series x-rays once in any 24 month period
- Periodontic scaling and root planning maximum 10 units per year
- Occlusal equilibration..... maximum 8 units per year
- Periodontal surgery 4 sites per calendar year
with one surgical
procedure per site.
- Pit and Fissure Sealants 1 application on any tooth
in any 24 month period.

Note: Services performed outside of the stated maximum frequency period will not be eligible expenses.

- Orthodontic Services for Adults and Dependent Children
- Stainless steel crowns for the restoration of Dependent Children's teeth.
- Anaesthesia is covered when performed with surgical procedures.
- Oral hygiene instruction is not a covered expense.
- Missing tooth limitation for Major dental services.
- Pit and Fissure Sealants for Dependent Children under age 14.

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

Termination age: 70

General Information

GENERAL INFORMATION

WHO IS ELIGIBLE TO ENROLL?

Eligibility of an Employee

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

- an active employee,
- employed by the employer and actively working on a regular permanent basis, by working full-time and not working on a seasonal basis,
- a member of an eligible class of employees eligible for the plan of group insurance coverage,
- insured under a provincial government health insurance plan,
- under age 70, and
- with regards to Long Term Disability, Extended Health Care (including Vision Care) and Dental Care benefits:
 - ⇒ have been actively employed for 3 months.

Note that if you are a new employee, and are age 70 or over, you will not be eligible for coverage. Also, if you will reach age 65 by the end of the long term disability elimination period, you are not eligible to join the long term disability plan.

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,
- 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.

Eligibility of a Dependent

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

Your spouse and/or dependent children may also qualify for coverage based on the following:

- Your spouse is a person of the same or opposite sex to whom you are legally married, or with whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse.
 - Benefits can be extended for a former spouse where you are required by court order to provide some or all of the benefits available under your plan. Note that you can only cover one person as your spouse for all benefits at any given time.
- Your dependent children are your or your spouse's unmarried natural, adopted, or step children, or any other unmarried children for whom you or your spouse have been appointed legal guardian. Your dependent child is eligible for coverage if he/she:
 - is under age 21 and not working more than 30 hours a week, unless a full-time student,
 - is under age 25 and registered as a student at a college, university, trade school or similar educational facility and attending on a full-time basis, or

General Information

- permanently incapacitated either prior to age 21 or while an eligible student (must be suffering from a permanent mental or physical infirmity and incapable of supporting himself/herself financially due to a medically diagnosed physical or psychiatric condition).
- ⇒ If your child is suffering from a medically diagnosed permanent mental or physical infirmity, or is a student, for continued coverage beyond age 21 you must submit a written application within 31 days of your child reaching age 21 and supply proof of their infirmity, or status as a student.
 - Your spouse's child is an eligible dependent if the child is also your natural or adopted child and your spouse is residing with you, insured under your plan and has custody of the child.
 - A child for whom you or your spouse has been appointed guardian is not an eligible dependent unless Co-operators Life has received satisfactory proof of guardianship. If your insured spouse is the guardian, the insured spouse must be residing with you.
 - A child is not considered a full-time student if the child is being paid while attending a training or re-training program at an educational institution, excluding scholarships. If you have dependent children who are students over age 21, you must submit proof of student status annually (by completing the student declaration form).

Dependent students outside Canada

Because dependents studying outside Canada are not eligible for emergency out-of-country coverage after the first 90 days, it's important that you purchase alternate coverage, such as travel insurance, before your dependent student leaves Canada.

You can only insure one spouse at a time

You must insure the same person for all spousal benefits provided under this plan. If you have more than one insurable spouse, Co-operators Life will consider your insured spouse to be the one for whom you first submit a claim for any benefit provided under this plan.

You can change from one insured spouse to another by submitting a claim for a different spouse for any dependent benefit provided under this plan. The change will take effect on the later of:

- the date of the loss claimed for the new spouse, and
- the day after the date of the last loss claimed for the previous spouse.

A change from a common-law spouse to a legal spouse is only valid when the legal spouse is living with you. A change from a former spouse to a legal spouse is not allowed unless the court order under which the former spouse qualified for coverage has expired.

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 complete and sign a group enrolment form to apply for group insurance coverage for yourself and/or your dependents.

This form should be signed and submitted to Co-operators Life within 31 days of satisfying employee/dependent eligibility requirements. If the form is submitted after this 31-day period, it is treated as a late application and you and your dependents will be required to provide health evidence of insurability. It is important to note that if you or your dependents are eligible to participate in this plan, it does not mean automatic coverage.

General Information

What if I have comparable coverage under my spouse's extended health care or dental care plan?

If you are insured under your spouse's health and/or dental plan at the time of application, you may waive comparable extended health and/or dental coverage offered by this plan. You will be required to complete and sign the section titled "Decline Option" on the group enrolment form.

Health Evidence of Insurability

When you submit your enrolment form, you may be asked to provide "Evidence of Insurability" before coverage begins.

You will also be required to provide medical evidence of insurability if:

- you or your dependents are a late applicant (you applied more than 31 days after becoming eligible),
- you wish to apply for an amount of insurance that is more than the amount available without evidence of insurability. Refer to the Schedule of Benefits, for the relevant benefit,
- you wish to apply for coverage you previously declined.

If evidence of insurability is required, you or your dependent should complete and submit a "Group Health Evidence Form". It must be received by Co-operators Life within 60 days of being completed and signed. Otherwise, this information is considered outdated and a new form will have to be completed. In some cases, Co-operators Life may request additional medical information from you after reviewing this form. Any charges for this information are your responsibility.

No insurance will take effect until all of the required information is received and approved, in writing, by Co-operators Life.

If you are declined for any amount in excess of the non-evidence maximum, you will still retain your coverage for the amount provided without evidence. If your initial application for coverage is declined, your dependent coverage will also be declined.

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.

WHEN DOES COVERAGE BEGIN?

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 employee eligibility requirements provided your completed enrolment form is received by Co-operators Life within 31 days of becoming eligible
- if health evidence of insurability is required, the date your insurability is approved by Co-operators Life.

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.

General Information

When does coverage for my dependents begin?

Your dependent coverage takes effect on the later of the following dates:

- the date your coverage begins
- the date the dependent becomes eligible for coverage
- if required, the date your dependent's health evidence of insurability is approved in writing by Co-operators Life.

Extended Health Care coverage for a dependent, who is hospitalized, other than a newborn child, will be delayed until the first day immediately following his/her discharge from the hospital.

What if coverage under my spouse's extended health care or dental care plan terminates?

If coverage under your spouse's health and/or dental plan terminates, either because the particular plan terminates or because your spouse becomes ineligible for either or both plans, you are eligible for immediate coverage under your company's extended health and /or dental care benefits. You must apply within 31 days of the date your spouse's coverage terminates. For any late application (after 31 days) evidence of insurability will be required and coverage will not be effective until the day the health evidence is approved.

Updating your records:

To ensure that coverage is kept-up-to-date, it is important that you report any of the following changes to your employer/plan administrator as soon as possible:

- change of dependents
- loss of spousal benefits
- change of name
- change of beneficiary

Designating your beneficiary:

Your designated beneficiary receives any benefits payable under the Life and Optional Life plans in the event of your death. As such, it's very important that you name a beneficiary when you enrol.

You have the right to name a beneficiary at the time you apply for 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 coverages under your plan.

What am I insured for?

The benefits and amounts for which you are insured are indicated on your group insurance benefit form, subject to the terms of the group insurance policy. You cannot be insured for more than the amount described in the Schedule of Benefits.

General Information

When do changes in the amount of my insurance take effect?

When a change in any circumstance would make you eligible for a different amount of insurance, the amount of insurance will be adjusted as follows:

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 active work for full pay if you were not actively at work for full pay on the date of the change, and
- the date any required evidence of insurability is approved by Co-operators Life,

provided a written request for increased insurance is received by Co-operators Life within 31 days of the date of the change.

Decrease in insurance:

If the change results in a decrease in the amount of insurance, the decrease will be effective on the date of the change.

What is meant by salary?

Your salary is the regular annual earnings (before deductions) paid to you by your employer.

Your Schedule of Benefits refers to a “Benefit Formula”. Each formula, unless it is a flat amount, is based on the reported insurable earnings that are sent (and updated on a regular basis) to Co-operators Life by your employer/plan administrator. Salary means your regular annual earnings paid by your employer to you, including the previous year’s annual bonus, exclusive of dividends, overtime pay, expense allowances and any other extra compensation.

Wherever monthly salary is indicated, 1/12 of your annual insurable earnings will be applied. For weekly salary, 1/52 will be applied.

Commissions:

If your regular earnings are made up in whole or in part from commissions, your insurable earnings will be the average of your regular rate of pay paid to you by your employer including commissions as shown on your T4-T4A Return for the previous 24 month period. If you have been employed less than 24 months, it will be averaged over the length of time employed.

Excluded earnings:

In all of the above instances, overtime pay, dividends, other expense allowances and extra compensation will be excluded.

Net salary:

Your net salary is your gross salary less involuntary deductions for federal and provincial income tax, Employment Insurance (EI) and Canada or Quebec Pension Plan (CPP or QPP).

What happens if my salary is understated or overstated?

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

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

General Information

WHEN DOES COVERAGE END?

Your coverage terminates the earliest of:

- the date your employment terminates (including retirement), or
- the date you are no longer actively at work except for:
 - maternity/parental leave where legislated, or
 - if you cease to be actively at work due to an approved leave, you may, at the Employer's election, be considered as still employed but not beyond the end of the 12th month in which you ceased to be actively at work, provided premium/deposit payment is received, or
 - if you cease to be actively at work due to lay-off, you may, at the Employer's election, be considered as still employed but not beyond the end of the month in which you ceased to be actively at work, provided premiums/deposit payments are received, or
- the end of a period for which premiums/deposit payments have been paid for your insurance, or
- the date you cease to be in a class of employees eligible for insurance, or
- the date you reach the applicable termination age specified in the Schedule of Benefits under each benefit, or
- the date of termination of your employer's group policy and/or plan text.

Your dependents' coverage terminates the earliest of:

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

THE CLAIMS PROCESS

Where do I find a claim form?

Claim forms are available from your employer, plan administrator or from our website www.cooperators.ca and click on *Group >Group Benefits >Forms*. All claim forms must be correctly completed, dated and signed. To avoid delays, always include your full name and personal identification number (i.e. certificate number), your employer name and your group policy number on any claim forms or correspondence submitted.

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 Co-operators Life to obtain information from other sources for this purpose (if required).

From time to time, Co-operators Life can require that you provide us with proof of your total disability. Whenever Co-operators Life requests 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.

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. You must submit a claim for any benefits on the Co-operators Life claim form provided to you by your employer or plan administrator.

General Information

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 should I submit my claim form?

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.

General Information

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 \$300, a detailed treatment plan should be submitted to the insurance company 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.

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.

Co-ordination of Extended Health and Dental Care Benefits

Co-operators Life will co-ordinate Extended Health Care and Dental Care 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.

When reimbursement is available under any government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered expense under all other co-ordination provisions. It is subject to any applicable deductible, co-coverage or co-payment level, and maximum under this Plan Text. Government plans are plans that are legislated, funded, or administered by a government.

Plans Co-ordinated with this Plan:

For the purpose of co-ordination of benefits, plan means:

- ⇒ other group insurance programs,
- ⇒ any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, including any pre-payment coverage, capitation plan, franchise plan or services plan, and
- ⇒ individual travel insurance plans.

Student accident plans are not considered group plans.

General Information

Order of Benefit Payment

1. The plan with no Co-ordination of Benefits (COB) provision in the policy or plan document is deemed to pay its benefits first (primary carrier). A secondary plan is one that determines its benefit after another plan.
2. If all plans have a Co-ordination of Benefits provision, the following rules are applied to determine the order of benefit payment. The rules depend on the basis on which the person is covered in the 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:

- (i) the plan covering the person as an active, full-time employee,
- (ii) the plan covering the person as an active, part-time employee,
- (iii) 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:

- (i) the plan covering the person as a dependent spouse,
- (ii) the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year,
- (iii) 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:

- (i) the plan of the parent with custody of the child,
- (ii) the plan of the spouse of the parent with custody of the child,
- (iii) the plan of the parent without custody of the child,
- (iv) the plan of the spouse of the parent without custody of the child.

Dental Accidents

In case of accidental injury to natural teeth, dental plans are secondary to Extended Health Care Plans with dental accident coverage.

Out-of-Country/Province Health Care Expenses

Where a person is also covered under more than one policy (for example, from employment related group insurance policy, individual or group travel or health policies, credit card coverage or any other private insurance sources) coverage will be co-ordinated with other policies according to the Co-ordinating Coverage Guidelines for Out-of-Country/Province Health Care Expenses provided by the Canadian Life and Health Insurance Association.

General Co-ordination of Benefits (COB) Information

If benefits have already been paid under another group plan, this plan is automatically secondary.

If these rules do not establish an order of benefit determination, or another plan has different rules, benefits will be prorated between plans in proportion to the amounts available before co-ordination.

General Information

Co-ordination of benefits will also take place within this plan if a person is covered as both an employee and a dependent under this plan or a person is covered as a dependent of two employees under this plan.

Right of Recovery

Whenever payments have been made by Co-operators Life in excess of the maximum amount necessary to satisfy the intent of the policy, Co-operators Life has the right to recover the excess payment from one or more of the following, as Co-operators Life will determine:

- (i) any persons to whom the payments were made, or
- (ii) any persons for whom the payments were made, or
- (iii) any other Insurance Companies, or
- (iv) any other organizations.

Submitting a claim for Co-ordination of Benefits

To submit a claim when co-ordination of benefits applies, refer to the following guidelines:

- ◆ refer to the order of benefit payment section, determine which plan is the primary carrier and which is the secondary carrier. Your employer/plan administrator can help you determine which plan you should claim from first.
- ◆ submit all necessary claim forms and original receipts to the primary carrier.
- ◆ keep a photocopy of each receipt or ask the primary carrier to return the original receipts to you once your claim has been settled.
- ◆ once your claim has been settled by the primary carrier, you will receive an explanation outlining how your claim has been handled.
- ◆ submit this explanation along with all necessary claim forms and receipts to the secondary carrier for further consideration or payment, if applicable.

Life Insurance Conversion Privilege

Where your basic life insurance (and/or your and your spouse's optional life insurance if applicable) reduces or terminates before age 65, you (and/or your spouse) may obtain an individual policy with Co-operators Life without providing evidence of good health.

The individual Life Insurance policy is available in the following forms:

- ◆ a Permanent Traditional Plan,
- ◆ a Term to age 65 Plan, or
- ◆ a One Year non-renewable Term Plan.

At Co-operators Life's rates in effect at the date of conversion based on the class of risk applicable to you and/or your spouse and the new policy (determined by Co-operators Life's rules at the time of conversion) and your or your spouse's then attained age (nearest birthday).

At age 65, you (or your spouse, if your spouse has optional life insurance under this plan) may convert to a Permanent Traditional Plan allowed by Co-operators Group Insurance department for the purpose of conversion at that time at the rate class determined by Co-operators Life's then current rules.

The Individual Life Policy will not include any Total Disability Benefits or Accidental Death Benefits or any other special benefit.

General Information

Amount of Insurance

Where your or your spouse's insurance reduces or terminates and the master policy and your employer's coverage under the policy remains in force, the Amount of Insurance which you or your spouse may convert will be limited to the lesser of:

- ◆ \$200,000, or
- ◆ the full amount of Basic Life Insurance (and Optional Life Insurance if applicable) at the time of termination less the full Amount of Insurance for which you (or your spouse) is eligible under a new group policy within 31 Days after termination of the insurance under this plan.

Premium

The premium for the Individual Life Insurance Policy will be based on the covered person's age (nearest birthday), sex, class of risk and on the type and amount of policy being issued at the time of conversion.

Termination of the master policy

If your or your spouse's insurance terminates due to termination of the master policy or termination of your employer's coverage under the master policy, the following will apply:

- (i) the amount of insurance that may be converted will not exceed three times the year's Maximum Pensionable Earnings as established under the Canada Pension Plan, and
- (ii) the conversion right will be limited to persons who have been insured under the employer's group life policy for at least five continuous years, and
- (iii) the conversion privilege will apply only if the insurance is not being replaced within 31 days by another contract of group insurance or if the insurance is being replaced by an amount that is less than the amount for which you (or your spouse) is eligible under (i) above.

Application for conversion

The Individual Life Policy will be issued if a written application (including the required first premium) is completed and received by Co-operators Life at its Regina office within 31 Days from the date the insurance under the master policy terminates. The Individual Life Policy will become effective on the day following the expiration of the 31 day period.

Death during the Conversion Period

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.

Subsequent Eligibility under the Master Policy

If you or your spouse obtains an Individual Policy through this provision and later becomes eligible for insurance under the master policy, the amount for which the person is eligible will be reduced by the amount of insurance remaining in force under the Individual Policy.

No Obligation to Advise

Co-operators Life is under no obligation to advise any person of their right to convert.

BASIC LIFE INSURANCE BENEFIT

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

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

The Benefit Formula refers to the amount of coverage for which you are eligible. If flat or unit amounts are indicated, these amounts are not related to your salary. Otherwise, your coverage is a multiple of your annual salary as reported to Co-operators Life by your employer/plan administrator, rounded to the next higher \$1,000. Any adjustment to your amount of coverage required due to a salary increase occurring while you are not actively at work (i.e. totally disabled or on maternity or parental leave etc.) will be deferred until you are again working on a regular basis.

Excess Life Insurance

If your salary qualifies you for an amount of insurance in excess of the Non-evidence Maximum (NEM) shown in the Schedule of Benefits, your basic group life insurance may be increased to an amount not exceeding the Health Evidence Maximum (HEM) shown in the Schedule of Benefits, provided evidence of good health is approved in writing by Co-operators Life.

Retirement Benefit

If you retire and are eligible to receive a pension, you will receive a \$5,000 paid-up certificate.

What if I become terminally ill?

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

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

When and how to submit a life claim

If the claim is the result of a death the claim form must be submitted to Co-operators Life within 6 months of the date of death.

Total Disability Benefits

Should you become Totally Disabled (as that term is defined in the Policy) for more than 119 days prior to age 65, the amount of your life insurance will continue without payment of premiums while you remain Totally Disabled. Satisfactory proof of Total Disability must be submitted to The Co-operators within 12 months from the date of Total Disability and thereafter, upon request by The Co-operators. Your life insurance coverage and waiver will terminate when you reach age 65 or recover, whichever occurs first.

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

DEPENDENT LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

In the event of the death of your insured dependent, Co-operators Life will pay the amount of insurance as shown in the Schedule of Benefits for your dependent.

Total Disability Waiver of Premium

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

When and how to submit a Dependent Life claim

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

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

OPTIONAL LIFE INSURANCE

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

You and/or your insured spouse may apply for an additional amount of life insurance as indicated in the Schedule of Benefits.

How do I apply?

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

Maximum Benefit

The amount of Optional Life insurance issued to you or your spouse will not exceed the maximum indicated in the Schedule of Benefits.

Termination of Optional Life Benefits

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

- termination of your Basic Group Life Insurance, or
- termination of this Optional Life Insurance Provision, or
- the cessation of premium payments for the Optional Life Insurance, or
- the date you reach the termination age as indicated in the Schedule of Benefits.

Total Disability Waiver of Premium

If premiums for your Basic Life Insurance coverage under the policy are being waived, then premiums for your (and your spouse's) Optional Life Insurance coverage will also be waived.

Suicide

No benefit will be payable where the cause of death is suicide occurring within 2 years from the date the covered person's Optional Life Coverage became effective.

When and how to submit an Optional Life claim

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

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

SICK LEAVE AND SHORT TERM DISABILITY

These benefits are provided by your employer.

SICK LEAVE

Eligibility

All permanent employees earn sick leave credits at the rate of one day per month. Any unused sick leave will accumulate from year to year.

Coverage

Sick leave benefits are paid at the rate of 100% of basic salary for a continuous period of up to fourteen calendar days. At this point employees may be eligible for the short term disability plan.

Employees who may be absent from work due to sickness or injury shall notify their immediate supervisor at once. A doctor's certificate may be required before sick credits will be paid.

SHORT TERM DISABILITY

Eligibility

All permanent employees are covered under this plan after three months continuous service.

Coverage

Benefits under this plan commence after 14 calendar days of continuous disability. Benefits are taxable and are paid at the rate of 70% of basic salary for a period of up to 15 weeks. Any unused sick leave credits can be used to top up the short term disability plan to a maximum of 100% of basic salary. A physician's report may be required before short term disability benefits are paid.

LONG TERM DISABILITY BENEFITS

Insurance provided by Co-operators Life Insurance Company

What am I insured for?

To qualify for benefits, your claim must provide satisfactory proof that, while insured under this plan, you became Totally Disabled (as that term is defined below) and therefore unable to work.

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

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

Definition of Total Disability:

"Total Disability" or "Totally Disabled" shall mean that you are, as a result of a Medically Diagnosed Condition:

- (i) unable to perform the usual and customary duties of your occupation during the Elimination Period and the next 24 months of Total Disability, and
- (ii) thereafter are prevented from engaging in any occupation or performing work of any sort for wage, remuneration or profit for which you are able or may reasonably become able, by means of education, training or experience and that will provide income of at least 75% of your pre-disability net monthly earnings, and
- (iii) is not engaged in any occupation or performing work of any sort for wage, remuneration or profit other than an approved Rehabilitation Program.

You will not, however, be considered to be Totally Disabled or prevented from engaging in any occupation or performing any work of any sort for wage, remuneration or profit by virtue of the unavailability of such occupation(s) or work in the place in which you reside.

Excess Long Term Disability Insurance:

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

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

Independent Medical Assessment

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

Continuous Obligation

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

Long Term Disability Benefits

Participation in Rehabilitation Program

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

Payment of Monthly Benefits

During the own occupation period

Where Co-operators Life receives satisfactory proof that you:

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

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

After the own occupation period

Where Co-operators Life receives satisfactory proof that you:

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

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

When will benefits begin?

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

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

What if I work during the Elimination Period?

If you return to active work for 7 consecutive days or less, your elimination period will be considered to be uninterrupted, but the days you worked will be added to the end of your elimination period.

If you return to active work for more than 7 days, your elimination period will be reinstated and you will be required to satisfy the complete elimination period before benefits are eligible to be paid.

Recurrence of Total Disability

Your total disability is considered a recurrence if it arises from the same or related sickness or injury, and it begins before you have completed:

Long Term Disability Benefits

- 6 months of continuous full-time active work if you are not participating in an approved rehabilitation program, or
- 12 months of continuous full-time active work if you are participating in an approved rehabilitation program.

Benefits are pro-rated for partial months

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

Are my benefits taxable?

Where you and all of the other employees in your classification, pay the full premium for the long term disability coverage, your monthly benefit will be non-taxable. The applicable tax status is indicated in the Schedule of Benefits.

Rehabilitation Program

“Rehabilitation Program” is a program provided at the sole discretion of Co-operators Life. A Rehabilitation Program may include rehabilitation assessment, and/or rehabilitative employment, and/or rehabilitative treatment, and/or rehabilitation services recommended and approved by Co-operators Life. The duration of a Rehabilitation Program must be approved by Co-operators Life.

Approval of Rehabilitation Program

Co-operators Life will have sole discretion in determining whether or not a rehabilitation program is appropriate and/or provided for any employee.

Once the rehabilitation program is approved, Co-operators Life may issue, if eligible, monthly benefits to a totally disabled employee who continues to participate and co-operate in an approved rehabilitation program.

The rehabilitation program will not extend beyond the end of your own occupation period (if applicable) or 24 months from the date of total disability, whichever is later, unless an extension of the duration is recommended and approved in writing by Co-operators Life.

Calculation of Monthly Benefits during a rehabilitation employment period

Where you participate in rehabilitative employment approved by Co-operators Life, the applicable Monthly Benefit will continue during the period of rehabilitative employment, but will be reduced by 50% of the rehabilitative earnings. "Rehabilitative Earnings" means the total earnings from rehabilitative employment if monthly indemnity benefits are taxable.

If monthly benefits are non-taxable, then it means the total earnings from rehabilitation employment less involuntary deductions for income tax, EI and CPP/QPP.

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

Long Term Disability Benefits

Your monthly benefits will cease on the earliest of:

- the date you refuse to participate or co-operate in any rehabilitation program recommended or approved by Co-operators Life including but not limited to any rehabilitation program offered through any worker's compensation act or similar statute, Auto Plan Benefits or Canada Pension Plan, or
- the withdrawal of Co-operators Life's approval of your rehabilitation program.

Cost of Living - Benefit Adjustment

Your long term disability benefit will be increased by a Cost of Living Adjustment ("COLA") as determined by this provision.

The first COLA will be applied on January 1 following 1 full calendar year (Jan 1 to Dec 31) of total disability from your disability date. Thereafter, the "COLA" is applied in January of each year to the monthly benefit you received in December of the previous year.

The COLA is the percentage increase in the Canadian Consumer Price Index ("CPI") for the year ending in the October immediately preceding the January 1 on which the COLA adjustment is made. There will be no adjustment if there is a decrease in the CPI.

The COLA will not exceed the percentage stated in the Schedule of Benefits.

Benefit Reductions:

What reductions occur when determining my Monthly Indemnity Benefit payment?

All Source Maximum - Ceiling on the Monthly Benefit

For non-taxable long term disability plans, the amount of your non-taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 100% of your pre-disability net monthly salary.

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

For taxable long term disability plans, the amount of your taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 100% of your pre-disability gross monthly salary.

All Source Compensation - Direct Reductions

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

- any government plan benefits,
- any auto plan benefits,
- any Canada or Quebec Pension Plan retirement benefits you apply for, were approved for and received after your disability date,
- any compensation for loss of income you receive from a third party or are entitled to receive after your disability date.

Long Term Disability Benefits

All Source Compensation - Indirect Reductions

Your benefit will be further reduced if the total of the following All Source Compensation and your monthly benefit exceeds 100% of your pre-disability gross monthly salary for taxable plans, your net monthly salary for non-taxable plans. If it does, your monthly benefit will be reduced by the amount in excess of 100% by:

- any amount you are entitled to under an employer funded salary replacement benefit as a result of your disability, and
- any compensation you receive or are eligible to receive while employed or while performing work of any sort, excluding rehabilitative earnings which are considered under the rehabilitation program, and
- any payment made to you by your employer as a result of termination of your employment including without limitation any payment made by way of settlement or judgement, and
- any disability benefits you are eligible to receive under any other group or association plan as a result of being an employee of a group or a member of an association.

Failure to Apply or Accept Other Benefits

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

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

Lump sum conversion to Monthly Benefit

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

The All Source Compensation used in the direct and indirect offset sections are the All Source Compensation Benefits payable for the same period as the monthly benefits are payable.

Repayment of Benefits

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

Total Disability Waiver of Premium

Co-operators Life will waive the long term disability premiums due while you are receiving monthly benefits. The premium waiver will begin with the first premium due after your first monthly benefits payment is made or eligible to be made.

Long Term Disability Benefits

When do my Long Term Disability Benefits terminate?

No monthly benefits will be paid beyond:

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

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

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

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

- serving a sentence for a criminal or provincial offense whether you are imprisoned in a half-way house, a correctional facility, or any other form of detention, or
- during any 12 month period where you do not reside in Canada for at least 6 months, or
- receiving short term disability benefits under this plan or salary continuation benefits from any other source, or
- on a temporary lay-off or on any leave of absence including maternity leave or parental leave except as provided below:

Maternity Leave, Parental Leave & Approved Leave of Absence

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

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

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

Long Term Disability Benefits

What limitations are there on LTD benefits?

No monthly benefits will be payable for any period of disability resulting directly or indirectly from any of the following:

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

When and how to submit an LTD claim

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

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

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

Extended Health Care Benefits

EXTENDED HEALTH CARE BENEFITS

Coverage administered by Co-operators Life Insurance Company

What am I covered for?

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

Assessment Standard:

All Allowable Expenses covered under the Extended Health Care Benefit provision must represent Reasonable and Customary Treatment of the Covered Person's Medically Diagnosed Condition.

"Reasonable and Customary Treatment" shall mean 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.

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.
- are incurred while you and your dependent are insured under this plan.

Reasonable and Customary Expenses are the lowest of:

- ▶ representative prices in the area where the service or supply was provided,
- ▶ prices shown in any applicable professional association fee guide, and
- ▶ maximum prices established by law.

Co-coverage Levels and Deductible Amounts

Allowable expenses are reimbursed at the co-coverage level indicated in the Schedule of Benefits. Extended Health Care Benefits are subject to any maximums identified for the covered services or supplies.

The deductible amounts shown in the Schedule of Benefits are applied each calendar year. They are applied as allowable expenses are incurred. No more than the individual deductible will apply to an individual employee's expenses. No more than the family deductible will apply to expenses for an employee with dependents.

The calendar year deductible amounts do not apply to certain coverages identified in the Schedule of Benefits.

Date Expenses are Incurred

For the purposes of all calculations made under the Extended Health Care Benefit plan, allowable expenses for services and supplies are considered to be incurred when the covered person receives them.

Extended Health Care Benefits

Covered Extended Health Care Services and Supplies:

To qualify for coverage the covered person (you and your covered dependents) must be covered by the Government Health Insurance Plan in the covered person's province of residence.

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 act or any similar statute, or
- 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. 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

Ambulance services, including air ambulance services, 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. Where medically necessary, the fee for 1 person to attend the covered person when being transported will be covered.

Hospital and Home Nursing Care

Hospital or nursing care is covered if:

- it starts while the covered person is covered under this Extended Health Care Benefit, and
- it represents Acute, Convalescent or Palliative care.

No benefits will be paid for hospital or 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.

Hospital Accommodation

Coverage is provided for the difference between the approved hospital's standard ward rate and the hospital accommodation shown in the Schedule of Benefits provided that accommodation was specifically elected in writing by the covered person.

Coverage is also provided for any out-of-province out-patient charge in an approved hospital not covered by the provincial Government Health Insurance Plan in the covered person's province of residence.

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

Convalescent Hospital Accommodation

Co-operators Life covers accommodation in a convalescent hospital for a medically diagnosed condition that requires convalescent care. Accommodation in a convalescent hospital must immediately follow at least 5 or more days of confinement in an approved hospital for a medically diagnosed condition that required acute care.

Extended Health Care Benefits

Co-operators Life covers the difference between the convalescent hospital's standard ward rate and the hospital accommodation shown in the Schedule of Benefits. For out-of-province hospital accommodation, any difference between the convalescent hospital's standard ward rate and the provincial Government Health Insurance Plan authorized allowance in the covered person's home province is also covered.

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

- ▶ it follows a period of at least 14 days during which no approved hospital or convalescent hospital confinement was required, or
- ▶ it is required for a medically diagnosed condition unrelated to the conditions for which benefits have already been paid.

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

Charges for the rental of a telephone, television, or similar equipment in a Hospital are not covered.

Home Nursing Care

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 this Policy.

Extended Health Care Benefits

Home Nursing Care Benefit

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

- (i) requires the skills and training of a professional nurse; and
- (ii) is provided by a professional nurse who is not a member of the Covered Person's family.

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

The maximum amount payable per calendar year 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" 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.

Out-of-Country Emergency Care

Out-of-Country Emergency care is provided for covered persons under age 70 for the first 90 days of travel 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 the Government Health Insurance Plan in their province of residence.

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 under this benefit provision.
- ▶ 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.

Extended Health Care Benefits

- ▶ Ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available.
- ▶ Dental accident treatment if it would have been covered under the Extended Health Care Provision of the policy had it been provided in Canada.

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

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

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

If you are referred by a physician for care outside of Canada, for care which is not available anywhere in Canada and a portion of the charges are paid by your provincial medical plan, reimbursement will be made for the following charges made by: a physician, an anaesthetist, a radiologist or a laboratory for x-rays, tests and x-ray or radium therapy, a hospital room (room and board charges are limited to the difference between the provincial medical allowance for room and board charges and the hospital's semi-private charge).

NOTE: "not available in Canada" would not include a service for which there may be a substantial waiting period.

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.

Extended Health Care Benefits

Paramedical Practitioners Services

Charges for out-of-hospital services of the following practitioners, 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.

- ▶ Chiropractor – treatment of muscle and bone disorders, including diagnostic x-rays, by a Chiropractor.
- ▶ Massage Therapist – treatment of muscle, tissue and joint disorders by a Massage Therapist.
- ▶ Naturopath – treatment by a Naturopath.
- ▶ Osteopath – treatment of musculoskeletal disorders, including diagnostic x-rays, by an Osteopath.
- ▶ Physiotherapist – treatment of movement disorders by a Physiotherapist.
- ▶ Podiatrist – treatment of foot disorders, including diagnostic x-rays, by a Podiatrist.
- ▶ Psychologist – treatment by a Psychologist.
- ▶ Speech Therapist – treatment of speech impairments by a Speech Therapist.
- ▶ Homeopath – treatment by a Homeopath.
- ▶ Reflexologist – treatment by a Reflexologist.
- ▶ Acupuncturist – treatment by an Acupuncturist.

Government Health Insurance Plan Coverage

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.

Optometrists/Ophthalmologist Expenses for Eye Exams

Charges for eye examinations by a licensed ophthalmologist or optometrist provided 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

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

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 in the drug formulary 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) drugs that must be injected, including vitamins, insulin and allergy extracts. Preventative vaccines are covered if they require a prescription by law.

Extended Health Care Benefits

- (iii) 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.
- (iv) 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
 - life sustaining drugs include, but are not limited to: insulin, diabetic test strips, disposable insulin needles and syringes, oral potassium supplements, Epi-Pen, Twinject, nitroglycerin for immediate release, low dose aspirin (80mg, 81mg or 325mg) for blood thinning, niacin for cholesterol lowering, vitamin B12 for certain types of anaemia.

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.
- oral 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, unless otherwise indicated in the Schedule of Benefits.
- 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-insurance amounts you are required to pay for yourself and any eligible dependents.

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.

Extended Health Care Benefits

Medical Supplies

Reasonable and customary charges for the medical supplies described under this section are covered when prescribed by a physician 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 to the maximum indicated in the schedule of benefits:

- ▶ insulin delivery pens.
- ▶ insulin infusion sets, not including infusion pumps.

The following diabetic supplies shall be covered by the way of a pay-direct card. The covered person may be required to pay a co-payment amount per expense if a pay-direct co-payment amount is indicated in the Schedule of Benefits.

- ▶ syringes.
- ▶ pen needles.
- ▶ test strips.
- ▶ lancets.

Diabetic monitoring 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.
- ▶ elastic (surgical) support stockings to the maximum amount payable is stated in the Schedule of Benefits.
- ▶ 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 medical equipment listed in the Schedule of Benefits required as a result of a Medically Diagnosed Condition.

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

Extended Health Care Benefits

Oxygen, Anaesthesia and Equipment

When ordered by a physician in connection with the treatment of a medically diagnosed condition, charges for the provision of anaesthesia and oxygen and the equipment needed for the administration of oxygen, blood and blood products, 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 indicated in the Schedule of Benefits.

In order to be eligible for reimbursement of expenses the orthopedic shoes and/or foot orthotics must be:

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

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

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

Wheelchairs and Hospital Beds

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.

Wigs and Hair Pieces

Coverage is provided for wigs or hairpieces as a result of alopecia or 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 amounts 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.

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.

Extended Health Care Benefits

Hearing Aids

Hearing aids, including repairs are covered. The maximum amount payable is indicated in the Schedule of Benefits.

Ostomy Supplies

The following colostomy and ileostomy supplies are covered:

- irrigation sets, bags, deodorants, pads, adhesives and skin creams.
- charges for catheters, catheterization supplies and urinary kits are also covered under this provision.

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 under this provision when:

- the accident occurs while the covered person is covered under the plan text, and
- treatment starts within 100 Days after the accident. This requirement is waived if a diagnosed medical condition delays treatment beyond 100 Days.

A sound tooth is any tooth that did not require restorative treatment immediately before the accidental injury. A natural tooth is any tooth that has not been artificially replaced.

Teeth that have been capped or crowned will be considered whole, sound and natural except where they have undergone endodontic treatment. Benefits will be payable under this provision if an accidental injury to a capped or crowned tooth causes damage to the remaining tooth structure requiring the preparation of a new cap or crown. No benefits will be payable under this provision if an existing cap or crown is damaged or dislodged without injury to the remaining tooth structure.

No accidental dental benefits will be paid for dental treatment performed more than 12 months after the date of the accident and must be the least expensive that will provide 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. Expenses for the treatment of temporomandibular joint dysfunction or orthodontic services are not covered under this provision.

Vision Care Benefits

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

Charges for laser eye surgery included in the maximum Vision Care benefit indicated in the Schedule of Benefits.

The maximum benefit payable to each covered person is indicated in the Schedule of Benefits. There is no coverage for any service or supply, which does not provide for the correction of one's vision.

Note: Eye examinations are not covered under the Vision Care Benefit. Please see the *Optometrists/Ophthalmologist Expenses for Eye Exams* section in this booklet.

Extended Health Care Benefits

Extended Health Care conversion privilege

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

Dependent Survivor Benefit

In the event of your death, your dependents will continue to receive these benefits, for the number of years as indicated in the Schedule of Benefits, provided this benefit remains in force under the master plan text and the dependent does not become eligible for benefits under any other group insurance plan as either an employee or dependent and the dependent remains eligible as defined in the plan text.

Extended Health Care General Limitations

No extended health care benefits will be paid for:

- Expenses that private insurers are not permitted to cover by law.
- Services or supplies payable by worker's compensation 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 group benefits coverage.
- Services or supplies that do not represent Reasonable and Customary Treatment of the Covered Person's Medically Diagnosed Condition.
- Allergy testing.
- Services or supplies classified as preventive treatment or administered for preventive purposes, and which is not specifically required for the treatment of an existing illness or injury.
- 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 otherwise indicated in the Schedule of Benefits;
 - ⇒ protein and dietary or food supplements whether or not prescribed for a medical reason;
 - ⇒ the diagnosis or treatment of infertility, unless otherwise indicated in the Schedule of Benefits;
 - ⇒ contraception, other than contraceptive drugs.
- Services or supplies:
 - ⇒ 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-Country or Out-of-Country Referral provision.
- Expenses incurred outside the province of residence for continuous or routine medical care normally covered by a government plan in the persons' province of residence.

Extended Health Care Benefits

- Expenses for 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.
- Expenses incurred for:
 - ⇒ the completion of claim forms;
 - ⇒ obtaining further medical information regarding claims for covered expenses;
 - ⇒ medical screening or examinations for the use of a Third Party;
 - ⇒ which no charge would ordinarily be made if there were no coverage;
 - ⇒ broken appointments, travel expenses or communication costs by a Medical Practitioner.
- 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 the Medical Practitioner or any other health practitioner 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 act or similar statute or a charitable organization, even if the Covered Person has opted-out of the 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 Care that was necessitated either wholly or partly, directly or indirectly as the result of committing suicide or attempting suicide.

When and how to submit an EHC claim

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

Dental Care Benefits

DENTAL CARE BENEFITS

Coverage administered by Co-operators Life Insurance Company

What am I covered for?

This benefit helps pay the cost of certain dental expenses incurred by you and your covered dependents. To qualify as an allowable expense, the dental treatment must be recommended by a dentist and performed by either a dentist, a dental hygienist under the supervision of a dentist or a licensed denturist operating within the scope of his licence.

You will be reimbursed for incurred allowable expenses, subject to the deductible, co-coverage amounts and benefit maximums indicated in the Schedule of Benefits.

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 in Alberta, "Fee Guide" shall mean the 1997 Alberta Dental Association fee guide, plus an inflationary adjustment as determined by Co-operators Life.

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

Co-operators Life will reimburse you for allowable expenses:

- ▶ that are incurred while you or your dependent is insured for them, and
- ▶ that exceed the deductible, if you are required to pay a deductible.

Dental benefits are payable to you unless assigned, in writing, to the attending dentist or denturist.

Covered Dental Expenses

Covered Dental expenses are the lesser of the actual charges and the reasonable and customary treatment expenses for covered services and supplies.

Reasonable and Customary Expenses are the lowest of:

- ▶ prices listed in the dental Fee Guide identified in the Schedule of Benefits, and
- ▶ representative prices in the area where the treatment was provided.

Dental Care Benefits

X-rays

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 and lower anterior teeth or where numerous restorations are involved. No benefits will be payable for the duplication or interpretation of radiographs.

Laboratory charges

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

Co-coverage Levels, Deductible Amounts and Maximums

Allowable expenses are reimbursed at the co-coverage levels indicated in the Schedule of Benefits. Dental Care Benefits are subject to any maximums indicated in the Schedule of Benefits and the maximums indicated in the Covered Dental Services section of this booklet.

Please note that services performed outside of the stated maximum frequency period will not be eligible expenses.

The deductible amounts shown in the Schedule of Benefits are applied each calendar year. They are applied as allowable expenses are incurred. No more than the individual deductible will apply to an individual employee's expenses. No more than the family deductible will apply to expenses for an employee with dependents.

Date Expenses are Incurred

For the purposes of all calculations made under the Dental Care Benefit Provision, allowable expenses are considered to be incurred when treatment is completed, other than orthodontic treatment. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment.

Alternate Benefit

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 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 24 month period if the dentist is changed, provided the plan has not paid for any other examination during the past 6 months.

Dental Care Benefits

- ▶ 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.
- ▶ Four 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 once every 6 months.
- ▶ Procedures for the extraction of teeth and their roots, including pre and post-operative care.
- ▶ Non-bonded amalgam (silver) and tooth coloured fillings on both front and back teeth for restoring the natural tooth surfaces. Stainless steel crowns are also covered. If bonded amalgams are performed, expenses will be limited to the cost of non-bonded amalgams.
- ▶ Simple space maintainers for keeping the space of a lost baby tooth until the permanent tooth comes in.
- ▶ Stainless steel crowns. Temporary stainless steel crowns must fulfil the same criteria as a regular crown to be a covered benefit. The cost of a stainless steel crown will be deducted from the cost of a permanent crown.
- ▶ Denture repairs, resetting and relining of removable denture teeth.
- ▶ Tissue Conditioning.
- ▶ Filing the surfaces (edges) of the teeth (interproximal discing).
- ▶ Pit and fissure sealants are covered for dependent children under 14 years of age.
- ▶ 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 Co-operators Life. If retreatment is payable, it will be considered as if it were initial treatment.
 - ⇒ Opening through a crown is not covered in conjunction with endodontic therapy.
 - ⇒ No benefits will be paid for enlargement of pulp chambers or endosseous intra coronal implants.
 - ⇒ Extra charges for difficult access, exceptional anatomy and calcified canals are not covered.

Dental Care Benefits

2. **Periodontics** - treatment of the soft tissue (gums).
- Scaling and root planing are limited to 10 time units for each service per calendar year.
 - occlusal adjustment and equilibration are limited to 8 time units for each service per calendar year.
 - Periodontal surgery is limited to 4 sites per calendar year with one surgical procedure per site. Reasonable and customary expenses are payable for anaesthesia 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 the dental consultant.

Level 3 – Major Restorative Covered Services:

All expenses under this level must be pre-determined.

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

Crowns, Onlays and related items:

- ▶ 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.
- ▶ Temporary stainless steel crowns for an adult must fulfil the same criteria as a regular crown to be a covered benefit. The cost of a stainless steel crown will be deducted from the cost of a permanent crown.

Replacement of existing crowns and onlays are covered when the existing restoration is at least 12 months old and cannot be made serviceable.

No benefits will be paid for:

- ▶ Crowns needed due to wear (attrition) and cosmetic reasons.
- ▶ Veneers.
- ▶ Covering of a tooth with a crown in order to prevent possible future damage to the tooth.
- ▶ Extra lab charges for a crown made to fit an existing partial denture clasp.

Dentures, Bridgework and Implants:

The following appliances are covered when required to replace one or more teeth extracted while the Covered Person was insured for major coverage under the Policy.

- ▶ Initial installation of standard complete dentures or overdentures, or
- ▶ Standard cast or acrylic partial removable dentures or fixed bridgework, or
- ▶ Tooth implantation and surgical insertion of fabricated implants.

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

Dental Care Benefits

Replacement appliances are also covered when:

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

Appliances will be replaced with similar appliances.

No benefits will be paid for:

- Services or supplies for equilibration of dentures, or denture cleaning or polishing.
- Replacement of dentures which are mislaid, lost or stolen. Denture repairs are covered under Basic Services.
- Services for precision attachments, oral rehabilitation, personalization or characterization or any charge for both a permanent and temporary crown or prosthesis in excess of the eligible charge for the permanent crown or prosthesis alone.

Level 4 – Orthodontic Covered Services:

Benefits are payable for orthodontic services performed after the effective date of the covered person's coverage under this plan.

Orthodontic Treatment

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

Orthodontic Treatment Plan:

For each course of orthodontic treatment, a treatment plan is required. The orthodontist must submit a treatment plan to Co-operators Life before treatment begins. 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 will 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 this dental plan replaces coverage for orthodontic services with a previous group insurance carrier, Co-operators Life 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 began prior to the effective date of coverage under this plan.

Dental Care Benefits

Payment of Orthodontic Services

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

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

Lost, mislaid or stolen orthodontic appliances will not be replaced.

Dental Care conversion privilege

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

Dependent Survivor Benefit

In the event of your death, your dependents will continue to receive these benefits for the number of years as indicated in the Schedule of Benefits, provided this benefit remains in force under the plan text and the dependent does not become eligible for benefits under any other group insurance plan as either an employee or dependent and the dependent remains eligible as defined in the plan text.

Dental Care General Limitations

No Dental Benefits will be paid for:

- ▶ Services or supplies not specifically listed as covered under Covered Dental Services.
- ▶ 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 act 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.
- ▶ Injection of antibiotic drugs.

Dental Care Benefits

- ▶ 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, and
 - ⇒ bacteriological tests or smears.

- ▶ Miscellaneous services:
 - ⇒ nutritional counselling, dental plaque control or oral hygiene instruction,
 - ⇒ treatment planning,
 - ⇒ completion of claim forms or pre-determinations,
 - ⇒ consultations, other than with specialists, and
 - ⇒ travel expenses, broken appointments or communication costs.

When and how to submit a Dental claim

The Insurance Company must receive written notice of a claim for dental care benefits within 12 months from the date the expense was incurred. If the policy terminates, or the dental care benefits terminated 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 Co-operators Life prior to the termination date.

Where there is no replacing dental insurance Co-operators Life will extend coverage for “Work in Progress” as follows:

- where an impression for a denture, bridge or crown was taken or the surgical component of an implant was inserted or root canal therapy was started in the 3 months prior to termination of 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 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 purpose of this provision, a dental charge or expense will be deemed to have been incurred as of the date of 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.

GROUP BASIC ACCIDENT INSURANCE PLAN

Insurance provided by Sutton Special Risk Inc.

Scope of Coverage

You are insured against the perils described in this booklet. Your protection is worldwide and applies for any injury sustained 24-Hours a day while your coverage is in force. Benefits are payable regardless of any other benefits that you may receive from any insurance company other than Sutton Special Risk Inc., or any other organization.

Definitions

“Principal Sum” means the amount indicated under **Applicable Principal Sum**.

“Male pronoun” wherever used includes the female.

“Spouse” means your Legal Spouse or Common-law Spouse or Former Spouse.

“Legal Spouse” means the person lawfully married to you according to the applicable Provincial legislation.

“Common-law Spouse” means a person who has been residing with you for a minimum of 12 consecutive months and has been publically represented as your Spouse. Discontinuation of cohabitation with you shall terminate coverage of the Common-law Spouse.

“Former Spouse” shall mean your divorced or ex-common-law spouse for whom you are required by Court Order to provide some or all of the benefits available under this Policy.

“Child or Children” shall mean an unmarried natural (legitimate or illegitimate), adopted, step-child, or foster child (of you or your Spouse) or any other unmarried child for whom you or your Spouse have been appointed guardian by a court and who in addition, satisfies one or more of the relevant criteria set out below:

- A Child under age 21 must not be working more than 30 hours a week, unless the child is a full-time Student.
- A Child age 21 or over must either be; a full-time student under age 25, or permanently incapacitated for a continuous period beginning before age 21 or while a full-time student and before age 25.
- A Child of your Insured Spouse is not an eligible Dependent unless the Child is also your Child or the Spouse is living with you, is insured and has custody of the child.
- A Child for whom you or your insured Spouse have been appointed guardian is not an eligible Dependent unless there is satisfactory proof of guardianship. If your Insured Spouse is the guardian, your Insured Spouse must be residing with you.
- A Child is considered a full-time student if the Child is registered at a high school, university, trade school, college or similar educational institution and attending on a full-time basis.

Group Basic Accident Insurance Plan

- 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.
- A Child is considered incapacitated if the Child is permanently incapable of supporting itself financially due to a medically diagnosed physical or psychiatric disorder and is totally dependent on you for support within the terms of the Income Tax Act of Canada.

Eligibility

You are eligible for coverage if you are an active Canadian full-time bargaining unit Employee (SK) under age 70.

Effective Date

Your insurance is effective on the first day of active work.

Applicable Principal Sum

You are insured for the Principal Sum indicated below:

Three (3) times Annual Earnings, rounded to the next higher \$1,000 (if not already a multiple thereof), to a maximum of CDN \$500,000

“**Annual Earnings**” shall mean your regular annual gross earnings paid by the Employer and reported to the Insurer, including the annual bonus for the previous year, but excluding any additional form of income such as but not limited to commissions, dividends and overtime earnings. If you are paid by commission, your annual earnings will be the average of earnings from the previous 24 months paid by the Employer, exclusive of bonuses or overtime, if employed less than 24 months, earnings will be averaged over the available length of service with the Employer.

Reduction/Termination Clause

Coverage reduces by 50% at age 65 and terminates at the earlier of age 70 or retirement.

What Benefits are Provided?

Loss Schedule

If your bodily injuries result in your Accidental Death, Dismemberment, Loss of Speech and/or Hearing, Paralysis and Loss of Use occurring within 12 months of the date of the accident, the Insurer will pay the percentage of the Principal Sum set opposite such loss. Each sum is calculated based on your amount of Principal Sum.

	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%

Group Basic Accident Insurance Plan

Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye.....	100%
Loss of One Arm.....	75%
Loss of One Leg.....	75%
Loss of One Hand	66.7%
Loss of One Foot.....	66.7%
Loss of Entire Sight of One Eye	66.7%
Loss of Thumb and Index Finger of Any One Hand.....	33.3%
Loss of Four Fingers of Any One Hand.....	33.3%
Loss of All Toes on One Foot.....	12.5%

Loss of Speech and Hearing in Both Ears.....	100%
Loss of Speech	66.7%
Loss of Hearing in Both Ears	66.7%
Loss of Hearing in One Ear.....	16.7%

Paraplegia (Both Lower Limbs).....	200%
Hemiplegia (Upper and Lower Limbs on the Same Side of the Body)	200%
Quadriplegia (Both Upper and Lower Limbs)	200%

Loss of Use of Both Hands	100%
Loss of Use of Both Arms.....	100%
Loss of Use of One Arm	75%
Loss of Use of One Leg	75%
Loss of Use of One Hand.....	66.7%
Loss of Use of One Foot	66.7%

NOTE: If more than one of the losses occur as the result of one accident, the total amount payable shall not exceed the Principal Sum or in the case of Paralysis, benefits shall not exceed 200% of the Principal Sum.

“Loss” means, with regard to:

Loss of Use:	Total and irrecoverable Loss of Use, provided the Loss of Use is continuous for 12 consecutive months, and such Loss of Use is determined to be permanent and irrecoverable at the end of such period.
Hands and Feet:	Actual severance through or above wrist or ankle joints.
Arms and Legs:	Actual severance through or above elbow or knee joints.
Thumbs and Fingers:	Actual severance through or above metacarpophalangeal joints.
Toes:	Actual severance through or above metatarsophalangeal joints.
Sight, Speech, Hearing:	Medical certification by a duly qualified physician that such Loss of Sight, Speech and Hearing are entire and irrecoverable.
Paralysis:	Irrecoverable and permanent Loss of Use of such limbs.

Group Basic Accident Insurance Plan

Exposure

If, while this coverage is in force, you are unavoidably exposed to the elements due to an accident and if, as the result of such exposure and within 365 days of the accident, you suffer a loss which would otherwise be payable, such loss will be covered.

Disappearance

If you disappear and your body is not found within one year and sufficient evidence is provided and confirms that you sustained accidental bodily injury which caused your death, the Insurer will pay the Principal Sum, provided that the person or persons to whom such sum is paid shall sign an undertaking to refund such sum to the Insurer if you are subsequently found to be living.

Aggregate Limit of Indemnity

Aggregate Limit of Indemnity per any one known accumulation: CDN \$30,000,000
Aggregate Limit of Indemnity per any one Aircraft accumulation: CDN \$3,500,000

The Insurer will not pay an amount that is more than the Aggregate Limit of Indemnity shown above. If the total amount claimed by all Insured Persons (including yourself) as a result of an accident is more than this limit, then the amount the Insurer pays for each Insured Person is equal to the Aggregate Limit of Indemnity, divided by the total amount claimed by all Insured Persons, multiplied by the amount claimed by each Insured Person.

Additional Benefits

Any benefits payable under the additional benefits shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable, unless specifically noted otherwise.

In the event that you are covered under two or more policies issued by the same Insurer, the Insurer's aggregate liability for loss sustained by you only in respect of the specific additional benefits noted with an asterisk (*) below, shall not be cumulative and shall in no event exceed the largest amount available under any one of the policies.

Repatriation Benefit*

The Insurer will pay an amount not to exceed \$10,000 for the customary and reasonable expenses incurred for preparation of your body for burial or cremation and transportation of your body from the place of the accident to your place of residence. Payment is made if, as the result of an accident, you suffer loss of life more than 50 kilometres from your place of residence.

Rehabilitation Benefit*

When an injury which does not cause your loss of life results in the Insurer making a payment under the Loss Schedule, an additional amount not to exceed \$10,000 will be paid for the reasonable and necessary expenses actually incurred for your special training, provided (i) you have to undergo training as the result of the injury in order to be qualified to engage in an occupation in which you would not have engaged in except for such injury, (ii) expenses are incurred within two years from the date of the accident, and (iii) no payment is made for room or board or other ordinary living, travelling or clothing expenses.

Group Basic Accident Insurance Plan

Spousal Retraining Benefit*

In the event your accidental loss of life results in the Insurer making a payment under the Loss Schedule, payment is made for the reasonable and necessary expenses actually incurred within two years from the date of the accident by your Spouse who engages in a formal occupational training program, specifically qualifying him for active employment in an occupation for which he would not otherwise have had sufficient qualifications. The maximum amount payable for all such expenses shall not exceed \$10,000. No payment is made for room, board or other ordinary living, travelling or clothing expenses.

To qualify for this benefit, your Spouse shall:

- a) not be employed in a full-time occupation on the date of the accident;
- b) enroll as a full-time student in a school of higher education or vocational training for the purpose of preparing for full-time employment.

Special Education Benefit*

Should you lose your life in an accident, the Insurer will pay, in addition to all other benefits, 5% of your Principal Sum, to a maximum of \$5,000, towards the cost of your dependent Child's education. The dependent Child must be enrolled as a full-time student in any institution of higher learning beyond the Secondary School level or at the Secondary School level and subsequently enroll as a full-time student in an institution of higher learning within 365 days following the accident.

This benefit is payable annually for a maximum of four consecutive annual payments, but only if the dependent Child continues his education.

If at the time of your death, your dependent Children are not eligible for the Special Education benefit, the Insurer will pay an amount of \$2,500 to your beneficiary.

“**Institution of higher learning**”, means an accredited institute, college, university, CEGEP or trade school.

Day Care Benefit*

In the event of your accidental loss of life, the Insurer will pay an amount equal to the lesser of:

- (1) the actual cost charged by the day care centre per year, or
- (2) 3% of your Principal Sum, or
- (3) \$5,000 per year,

on behalf of any dependent Child who, at the time of your accidental loss of life, is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care centre within 90 days following such loss.

This benefit is payable annually for a maximum of four consecutive annual payments, but only if the dependent Child continues his enrollment in an accredited day care centre.

If at the time of your death, your dependent Children are not eligible for the Day Care Benefit, the Insurer will pay an amount of \$1,500 to your beneficiary.

Group Basic Accident Insurance Plan

Family Transportation Benefit*

If you are injured while on a trip due to an accident which occurs more than 200 kilometres from your place of residence and are confined as an inpatient in a hospital because of such injuries and you require the personal attendance of a member of the immediate family or an authorized family representative, as recommended by the attending physician, payment is made for the expenses incurred by the family member or the authorized family representative, for accommodation and transportation to your bedside by the most direct route by a licensed common carrier. The maximum amount payable for such expenses will not exceed \$10,000.

Payment will not be made for board or ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle other than by a licensed common carrier, then reimbursement of transportation expenses will be limited to a maximum of \$0.30 per kilometre travelled.

“**Member of the immediate family**” means your spouse (or common-law spouse), parents, grandparents, children over age 18, brother or sister.

Home Alteration and Vehicle Modification Benefit*

If you receive a payment under the Loss Schedule and you are subsequently required due to the cause of the same accident, to use a wheelchair, this benefit will pay, upon presentation of proof of payment:

- (A) the one-time cost of alterations to your residence to make it wheel-chair accessible and habitable; and
- (B) the one-time cost of modifications necessary to your motor vehicle to make it accessible or driveable.

Benefit payments will not be made unless:

- (1) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users,
- (2) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities, and
- (3) expenses are actually incurred within two years from the date of the accident.

The maximum payable under both items A and B combined will not exceed \$10,000.

Seat Belt Benefit

When an injury to you results in the Insurer making a payment under the Loss Schedule, the Insurer will increase the benefit amount payable by an additional 10%, provided that:

- 1. the loss occurs while you are a passenger or driver of a private passenger type Vehicle;
- 2. the Seat Belt is properly fastened; and
- 3. verification of the actual use of the Seat Belt is part of the official report of the accident or certified by the investigating officer.

Group Basic Accident Insurance Plan

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the accident occurs.

"Physician" means a doctor of medicine (other than yourself or a Member of the Immediate Family) licensed to practice medicine by:

1. a recognized medical licensing organization in the locale where the treatment is rendered, or
2. a governmental agency having a jurisdiction over such licensing in the locale where the treatment is rendered.

"Member of the Immediate Family" means a person at least eighteen (18) years of age, who is your son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the previous include natural, adopted and step relationships), spouse, grandson, granddaughter, grandfather or grandmother.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a seat belt and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

"Vehicle" means a passenger car, self-propelled motor home, station wagon, van, jeep-type automobile or truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

Waiver of Premium Benefit

If you are totally disabled and your life insurance is extended under a waiver of premium provision under your Group Life Insurance policy, coverage provided under this policy will also be extended and waiver of premium will be provided in accordance with the same terms and conditions as the Group Life Insurance policy.

Coverage provided for under this provision will be subject to the terms and conditions of this policy in effect as of the date of commencement of disability, including any conditions providing for reduction in amounts of insurance.

Notwithstanding anything contained in the contrary in the policy, in no event will benefits payable for any loss which occurs while coverage is being continued under this provision exceed your Principal Sum at the date of commencement of disability, less any amounts of indemnity which were payable prior to such loss as the result of the same accident.

Continuation of Coverage Benefit

Your coverage will continue while you are on an approved leave of absence (including maternity leave or parental leave) or lay-off (subject to payment of premiums) as outlined below:

- Approved Leave of Absence: coverage will be continued for an approved leave of absence to a maximum of 12 months from the commencement of the leave.
- Lay off: For lay off, coverage terminates at the end of the month.

Group Basic Accident Insurance Plan

Conversion

If your insurance is terminated for any reason other than non-payment of premium or attainment of age 70, you may convert your coverage to an individual policy of insurance on the form provided by the Insurer for conversion. Application for the converted policy and the initial premium must be received within 60 days of the date of termination and the effective date will be the latter of (1) the date of termination under this policy or (2) the date of application for the converted insurance.

The Principal Sum under the converted policy can be equal to or less than the Principal Sum under this policy, to a maximum of \$200,000 (subject to a minimum of \$25,000). The premium for the converted policy will be the Insurer's rate in effect at the time of conversion for the Class of risk and your age as of the effective date of the converted insurance. No medical evidence of insurability is required.

Exclusions

This insurance does not cover any claim arising out of bodily injury caused or contributed to by:

- a) declared or undeclared war or any act thereof or invasion;
- b) actively participating in acts of terrorism, civil commotions or riots of any kind;
- c) training, serving or taking part in any capacity in the armed forces (land, sea or air) or their operations, of any country or international authority;
- d) while serving as a pilot or crew member of any aircraft or while as a passenger in an aircraft which is being used for a purpose other than transportation;
- e) suicide or attempted suicide or intentional self-injury;
- f) injury sustained while you are riding in, boarding or alighting from an aircraft owned or leased, by or on behalf of the Insured, or any subsidiary or affiliate of such Insured, unless specific written agreement has been obtained from the Insurer; or
- g) acts of terrorism which involve the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s).

“Acts of terrorism” means any act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Payment of Benefits

Your accidental death benefit is paid to the beneficiary designated on your Group Life Insurance application on file with the Insured or to your Estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

Group Basic Accident Insurance Plan

Claim Procedures

To make a claim under this plan, written proof of claim must be submitted to the Insurer as outlined below:

Accidental Death Claim

If the claim is a result of an accidental death, the claim form must be submitted to the Insurer within 6 months from the date of death.

Accidental Dismemberment Claim

If the claim is for a Dismemberment benefit, the claim form must be submitted to the Insurer within 12 months from the date of the loss.

Failure to furnish proof of claim within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after first becoming eligible for accidental death benefits or 18 months for accidental dismemberment benefits.

The Insurer will provide the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

Disclaimer

This booklet should be kept with your Employee Handbook. It is a summary of the principal features of the plan which is governed by the terms of the Group Master Policy, 056/019808A, with the Human Resources Department. In the event of any discrepancy between this booklet and the master policy, the master policy prevails.

Underwritten by:

Certain Underwriters at
Lloyds, London through
Sutton Special Risk Inc.
33 Yonge Street, Suite 270
P.O. Box 311
Toronto, Ontario
M5E 1G4

(10/13)

GROUP BUSINESS TRAVEL ACCIDENT INSURANCE PLAN

Insurance provided by Sutton Special Risk Inc.

Scope of Coverage

You are insured against the perils described in this booklet. Your protection is worldwide and applies for any injury sustained 24-Hours a day while on the business of the Insured (ISM Information Systems Management Canada Corporation) during any bonafide trip made. Such trip shall be deemed to have commenced when you leave your residence or place of regular employment for the purpose of going on such trip, whichever last occurs, and shall continue until you return to your residence or place of regular employment, whichever first occurs.

“While on the Business of the Insured” means furthering the business of ISM Information Systems Management Canada Corporation. Injury sustained during the course of everyday travel to and from work and bonafide leaves of absence or vacations shall not be deemed to be sustained while on the business of the Insured.

Definitions

“**Principal Sum**” means the amount indicated under **Applicable Principal Sum**.

“**Male pronoun**” wherever used includes the female.

“**Spouse**” means your Legal Spouse or Common-law Spouse or Former Spouse.

“**Legal Spouse**” means the person lawfully married to you according to the applicable Provincial legislation.

“**Common-law Spouse**” means a person who has been residing with you for a minimum of 12 consecutive months and has been publically represented as your Spouse. Discontinuation of cohabitation with you shall terminate coverage of the Common-law Spouse.

“**Former Spouse**” shall mean your divorced or ex-common-law spouse for whom you are required by Court Order to provide some or all of the benefits available under this Policy.

“**Child or Children**” shall mean an unmarried natural (legitimate or illegitimate), adopted, step-child, or foster child (of you or your Spouse) or any other unmarried child for whom you or your Spouse have been appointed guardian by a court and who in addition, satisfies one or more of the relevant criteria set out below:

- A Child under age 21 must not be working more than 30 hours a week, unless the child is a full-time Student.
- A Child age 21 or over must either be; a full-time student under age 25, or permanently incapacitated for a continuous period beginning before age 21 or while a full-time student and before age 25.
- A Child of your Insured Spouse is not an eligible Dependent unless the Child is also your Child or the Spouse is living with you, is insured and has custody of the child.

Group Business Travel Accident Insurance Plan

- A Child for whom you or your insured Spouse have been appointed guardian is not an eligible Dependent unless there is satisfactory proof of guardianship. If your Insured Spouse is the guardian, your Insured Spouse must be residing with you.
- A Child is considered a full-time student if the Child is registered at a high school, university, trade school, college or similar educational institution and attending on a full-time basis.
- 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.
- A Child is considered incapacitated if the Child is permanently incapable of supporting itself financially due to a medically diagnosed physical or psychiatric disorder and is totally dependent on you for support within the terms of the Income Tax Act of Canada.

Eligibility

You are eligible for coverage if you are an active Canadian full-time bargaining unit Employee (SK) under age 70.

Effective Date

Your insurance is effective on the first day of active work.

Applicable Principal Sum

You are insured for the Principal Sum indicated below:

Two (2) times Annual Earnings, rounded to the next higher \$1,000 (if not already a multiple thereof), to a maximum of CDN \$500,000

“**Annual Earnings**” shall mean your regular annual gross earnings paid by the Employer and reported to the Insurer, including the annual bonus for the previous year, but excluding any additional form of income such as but not limited to commissions, dividends and overtime earnings. If you are paid by commission, your annual earnings will be the average of earnings from the previous 24 months paid by the Employer, exclusive of bonuses or overtime, if employed less than 24 months, earnings will be averaged over the available length of service with the Employer.

Reduction/Termination Clause

Coverage reduces by 50% at age 65 and terminates at the earlier of age 70 or retirement.

What Benefits are Provided?

Loss Schedule

If your bodily injuries result in your Accidental Death, Dismemberment, Loss of Speech and/or Hearing, Paralysis and Loss of Use occurring within 12 months of the date of the accident, the Insurer will pay the percentage of the Principal Sum set opposite such loss. Each sum is calculated based on your amount of Principal Sum.

Group Business Travel Accident Insurance Plan

	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Arm	75%
Loss of One Leg	75%
Loss of One Hand	66.7%
Loss of One Foot	66.7%
Loss of Entire Sight of One Eye	66.7%
Loss of Thumb and Index Finger of Any One Hand	33.3%
Loss of Four Fingers of Any One Hand	33.3%
Loss of All Toes on One Foot	12.5%
Loss of Speech and Hearing in Both Ears	100%
Loss of Speech	66.7%
Loss of Hearing in Both Ears	66.7%
Loss of Hearing in One Ear	16.7%
Paraplegia (Both Lower Limbs)	200%
Hemiplegia (Upper and Lower Limbs on the Same Side of the Body)	200%
Quadriplegia (Both Upper and Lower Limbs)	200%
Loss of Use of Both Hands	100%
Loss of Use of Both Arms	100%
Loss of Use of One Arm	75%
Loss of Use of One Leg	75%
Loss of Use of One Hand	66.7%
Loss of Use of One Foot	66.7%

NOTE: If more than one of the losses occur as the result of one accident, the total amount payable shall not exceed the Principal Sum or in the case of Paralysis, benefits shall not exceed 200% of the Principal Sum.

“Loss” means, with regard to:

Loss of Use:	Total and irrecoverable Loss of Use, provided the Loss of Use is continuous for 12 consecutive months, and such Loss of Use is determined to be permanent and irrecoverable at the end of such period.
Hands and Feet:	Actual severance through or above wrist or ankle joints.
Arms and Legs:	Actual severance through or above elbow or knee joints.
Thumbs and Fingers :	Actual severance through or above metacarpophalangeal joints.
Toes:	Actual severance through or above metatarsophalangeal joints.
Sight, Speech, Hearing:	Medical certification by a duly qualified physician that such Loss of Sight, Speech and Hearing are entire and irrecoverable.
Paralysis:	Irrecoverable and permanent Loss of Use of such limbs.

Group Business Travel Accident Insurance Plan

Exposure

If, while this coverage is in force, you are unavoidably exposed to the elements due to an accident and if, as the result of such exposure and within 365 days of the accident, you suffer a loss which would otherwise be payable, such loss will be covered.

Disappearance

If you disappear and your body is not found within one year and sufficient evidence is provided and confirms that you sustained accidental bodily injury which caused your death, the Insurer will pay the Principal Sum, provided that the person or persons to whom such sum is paid shall sign an undertaking to refund such sum to the Insurer if you are subsequently found to be living.

Aggregate Limit of Indemnity

Aggregate Limit of Indemnity per any one known accumulation: CDN \$10,000,000
Aggregate Limit of Indemnity per any one Aircraft accumulation: CDN \$3,500,000

The Insurer will not pay an amount that is more than the Aggregate Limit of Indemnity shown above. If the total amount claimed by all Insured Persons (including yourself) as a result of an accident is more than this limit, then the amount the Insurer pays for each Insured Person is equal to the Aggregate Limit of Indemnity, divided by the total amount claimed by all Insured Persons, multiplied by the amount claimed by each Insured Person.

Additional Benefits

Any benefits payable under the additional benefits shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable, unless specifically noted otherwise.

In the event that you are covered under two or more policies issued by the same Insurer, the Insurer's aggregate liability for loss sustained by you only in respect of the specific additional benefits noted with an asterisk (*) below, shall not be cumulative and shall in no event exceed the largest amount available under any one of the policies.

Repatriation Benefit*

The Insurer will pay an amount not to exceed \$10,000 for the customary and reasonable expenses incurred for preparation of your body for burial or cremation and transportation of your body from the place of the accident to your place of residence. Payment is made if, as the result of an accident, you suffer loss of life more than 50 kilometres from your place of residence.

Rehabilitation Benefit*

When an injury which does not cause your loss of life results in the Insurer making a payment under the Loss Schedule, an additional amount not to exceed \$10,000 will be paid for the reasonable and necessary expenses actually incurred for your special training, provided (i) you have to undergo training as the result of the injury in order to be qualified to engage in an occupation in which you would not have engaged in except for such injury, (ii) expenses are incurred within two years from the date of the accident, and (iii) no payment is made for room or board or other ordinary living, travelling or clothing expenses.

Group Business Travel Accident Insurance Plan

Spousal Retraining Benefit*

In the event your accidental loss of life results in the Insurer making a payment under the Loss Schedule, payment is made for the reasonable and necessary expenses actually incurred within two years from the date of the accident by your Spouse who engages in a formal occupational training program, specifically qualifying him for active employment in an occupation for which he would not otherwise have had sufficient qualifications. The maximum amount payable for all such expenses shall not exceed \$10,000. No payment is made for room, board or other ordinary living, travelling or clothing expenses.

To qualify for this benefit, your Spouse shall:

- a) not be employed in a full-time occupation on the date of the accident;
- b) enroll as a full-time student in a school of higher education or vocational training for the purpose of preparing for full-time employment.

Family Transportation Benefit*

If you are injured while on a trip due to an accident which occurs more than 200 kilometres from your place of residence and are confined as an inpatient in a hospital because of such injuries and you require the personal attendance of a member of the immediate family or an authorized family representative, as recommended by the attending physician, payment is made for the expenses incurred by the family member or the authorized family representative, for accommodation and transportation to your bedside by the most direct route by a licensed common carrier. The maximum amount payable for such expenses will not exceed \$10,000.

Payment will not be made for board or ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle other than by a licensed common carrier, then reimbursement of transportation expenses will be limited to a maximum of \$0.30 per kilometre travelled.

“**Member of the immediate family**” means your spouse (or common-law spouse), parents, grandparents, children over age 18, brother or sister.

Home Alteration and Vehicle Modification Benefit*

If you receive a payment under the Loss Schedule and you are subsequently required due to the cause of the same accident, to use a wheelchair, this benefit will pay, upon presentation of proof of payment:

- (A) the one-time cost of alterations to your residence to make it wheel-chair accessible and habitable; and
- (B) the one-time cost of modifications necessary to your motor vehicle to make it accessible or driveable.

Benefit payments will not be made unless:

- (1) home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users,
- (2) vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities, and

Group Business Travel Accident Insurance Plan

(3) expenses are actually incurred within two years from the date of the accident.

The maximum payable under both items A and B combined will not exceed \$10,000.

Exclusions

This insurance does not cover any claim arising out of bodily injury caused or contributed to by:

- a) declared or undeclared war or any act thereof or invasion;
- b) actively participating in acts of terrorism, civil commotions or riots of any kind;
- c) training, serving or taking part in any capacity in the armed forces (land, sea or air) or their operations, of any country or international authority;
- d) while serving as a pilot or crew member of any aircraft or while as a passenger in an aircraft which is being used for a purpose other than transportation;
- e) suicide or attempted suicide or intentional self-injury;
- f) injury sustained while you are riding in, boarding or alighting from an aircraft owned or leased, by or on behalf of the Insured, or any subsidiary or affiliate of such Insured, unless specific written agreement has been obtained from the Insurer; or
- g) acts of terrorism which involve the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s).

“Acts of terrorism” means any act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Payment of Benefits

Your accidental death benefit is paid to the beneficiary designated on your Group Life Insurance application on file with the Insured or to your Estate if no such designation is made. Any other benefits are paid to you (those described in the Loss Schedule are paid as a percentage of the Principal Sum).

Claim Procedures

To make a claim under this plan, written proof of claim must be submitted to the Insurer as outlined below:

Accidental Death Claim

If the claim is a result of an accidental death, the claim form must be submitted to the Insurer within 6 months from the date of death.

Accidental Dismemberment Claim

If the claim is for a Dismemberment benefit, the claim form must be submitted to the Insurer within 12 months from the date of the loss.

Group Business Travel Accident Insurance Plan

Failure to furnish proof of claim within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after first becoming eligible for accidental death benefits or 18 months for accidental dismemberment benefits.

The Insurer will provide the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

Disclaimer

This booklet should be kept with your Employee Handbook. It is a summary of the principal features of the plan which is governed by the terms of the Group Master Policy, 056/019810A, with the Human Resources Department. In the event of any discrepancy between this booklet and the master policy, the master policy prevails.

Underwritten by:

Certain Underwriters at
Lloyds, London through
Sutton Special Risk Inc.
33 Yonge Street, Suite 270
P.O. Box 311
Toronto, Ontario
M5E 1G4

(10/13)

GROUP VOLUNTARY ACCIDENT INSURANCE PLAN

Insurance provided by Sutton Special Risk Inc.

Why is this plan so important?

No one likes to think about accidents.

Insurance cannot prevent them but it can protect you and your family against the severe financial hardships that accompany sudden accidental death, dismemberment or loss of sight. While the personal loss is irreparable, it is possible by means of this insurance to minimize the economic consequences.

Accident insurance should not be considered a replacement for Life Insurance. However, recent years have brought an unfortunate increase in serious accidents of all kinds. Our daily newspapers report tragedies, involving people at work, at play, in airline and snowmobile accidents, and even in those home activities we usually think of as safe. Accident insurance is a means of increasing your financial protection significantly, at a fraction of the cost of Life Insurance.

Scope of Coverage

You are covered (your Spouse and Children are also covered if you have elected the Family Plan) for accidents which may occur anywhere at any time – on or off the job – while travelling or at home, including travel as a passenger in any scheduled aircraft. The insurance is in effect 24 hours a day, 7 days a week.

Benefits are payable regardless of any other benefits that you, your Spouse or your dependent Children may receive from any insurance company other than Sutton Special Risk Inc., or any other organization.

Definitions

“Insured Person” means you, your insured Spouse or your Dependent Children.

“Principal Sum” means the amount you select and which is stated on the most recently signed enrollment card on file with your Human Resources Department.

“Spouse” means your Legal Spouse or Common-law Spouse or Former Spouse.

“Legal Spouse” means the person lawfully married to you according to the applicable Provincial legislation.

“Common-law Spouse” means a person who has been residing with you for a minimum of 12 consecutive months and has been publically represented as your Spouse. Discontinuation of cohabitation with you shall terminate coverage of the Common-law Spouse.

“Former Spouse” shall mean your divorced or ex-common-law spouse for whom you are required by Court Order to provide some or all of the benefits available under this Policy.

Group Voluntary Accident Insurance Plan

“**Child or Children**” shall mean an unmarried natural (legitimate or illegitimate), adopted, step-child, or foster child (of you or your Spouse) or any other unmarried child for whom you or your Spouse have been appointed guardian by a court and who in addition, satisfies one or more of the relevant criteria set out below:

- A Child under age 21 must not be working more than 30 hours a week, unless the child is a full-time Student.
- A Child age 21 or over must either be; a full-time student under age 25, or permanently incapacitated for a continuous period beginning before age 21 or while a full-time student and before age 25.
- A Child of your Insured Spouse is not an eligible Dependent unless the Child is also your Child or the Spouse is living with you, is insured and has custody of the child.
- A Child for whom you or your insured Spouse have been appointed guardian is not an eligible Dependent unless there is satisfactory proof of guardianship. If your Insured Spouse is the guardian, your Insured Spouse must be residing with you.
- A Child is considered a full-time student if the Child is registered at a high school, university, trade school, college or similar educational institution and attending on a full-time basis.
- 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.
- A Child is considered incapacitated if the Child is permanently incapable of supporting itself financially due to a medically diagnosed physical or psychiatric disorder and is totally dependent on you for support within the terms of the Income Tax Act of Canada.

“**Institution of higher learning**”, means an accredited institute, college, university, CEGEP or trade school.

Eligibility

You are eligible for coverage if you are an active Canadian full-time bargaining unit Employee (SK) under age 70.

Your Spouse and/or your Dependent Children may also be covered if you so choose. It is completely voluntary; you choose the amount that you would like to have and then the premium is collected by payroll deduction.

Effective Date

Your insurance will become effective at 12:01 a.m. on the first day of the month coincident with or next following the date of receipt of your enrollment card by the Human Resources Department.

Group Voluntary Accident Insurance Plan

How May I Enroll?

It is quite easy to enroll in this plan. Simply complete the enrollment card provided by the Human Resources Department.

1. **Select the type of plan desired:** Employee Plan or Family Plan.
2. **Select the amount of insurance you desire.**
3. **Complete the enrollment card and return it to your Human Resources Department.** Keep a copy of the enrollment card for your records and reference.

Note: To allow for processing, your enrollment card must be received by the 20th of the month for coverage to be effective on the first of the month following.

What Amounts are Available?

You may elect to insure yourself only **OR** yourself and your family under one of the plans outlined below:

1: Employee Plan

You may select amounts of insurance from a minimum of \$25,000 to a maximum of CDN \$250,000, in units of \$25,000.

2: Family Plan

You may select amounts of insurance from a minimum of \$25,000 to a maximum of CDN \$250,000, in units of \$25,000, and your family is automatically insured for the following:

(a) Spouse

Your Spouse is insured for 40% of the amount you elect for yourself if you have Dependent Children or 50% if you do not.

(b) Each Dependent Child

Each Dependent Child is insured for 10% of your amount if you have a Spouse or 15% if you do not.

Cost of Insurance

Premiums are payable by payroll deductions. The premium rate for the Employee Plan is \$0.015 per month for each \$1,000 of insurance. The premium rate for the Family Plan is \$0.023 per month for each \$1,000 of insurance.

Group Voluntary Accident Insurance Plan

Benefit and Premium per Month

Benefit Amount	Employee Plan	Family Plan
\$25,000	\$0.38	\$0.58
\$50,000	\$0.75	\$1.15
\$75,000	\$1.13	\$1.73
\$100,000	\$1.50	\$2.30
\$125,000	\$1.88	\$2.88
\$150,000	\$2.25	\$3.45
\$175,000	\$2.63	\$4.03
\$200,000	\$3.00	\$4.60
\$225,000	\$3.38	\$5.18
\$250,000	\$3.75	\$5.75

Example:

If you select \$100,000 of coverage, the amounts insured are:

- (A) **Employee Plan**
Employee \$100,000

- (B) **Family Plan**
Employee \$100,000
Spouse (40%) \$ 40,000
Each Child (10%) \$ 10,000

Your payroll deduction is:
Employee Plan..... \$1.50
Family Plan \$2.30

What Benefits are Provided?

Loss Schedule

If the Insured Person's bodily injuries result in Accidental Death, Dismemberment, Loss of Speech and/or Hearing, Paralysis and Loss of Use occurring within 12 months of the date of the accident, the Insurer will pay the percentage of the Principal Sum set opposite such loss. Each sum is calculated based on the Insured Person's amount of Principal Sum.

Group Voluntary Accident Insurance Plan

	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Arm	75%
Loss of One Leg	75%
Loss of One Hand	66.7%
Loss of One Foot	66.7%
Loss of Entire Sight of One Eye	66.7%
Loss of Thumb and Index Finger of Any One Hand	33.3%
Loss of Four Fingers of Any One Hand	33.3%
Loss of All Toes on One Foot	12.5%
Loss of Speech and Hearing in Both Ears	100%
Loss of Speech	66.7%
Loss of Hearing in Both Ears	66.7%
Loss of Hearing in One Ear	16.7%
Paraplegia (Both Lower Limbs)	200%
Hemiplegia (Upper and Lower Limbs on the Same Side of the Body)	200%
Quadriplegia (Both Upper and Lower Limbs)	200%
Loss of Use of Both Hands	100%
Loss of Use of Both Arms	100%
Loss of Use of One Arm	75%
Loss of Use of One Leg	75%
Loss of Use of One Hand	66.7%
Loss of Use of One Foot	66.7%

NOTE: If more than one of the losses occur as the result of one accident, the total amount payable shall not exceed the Principal Sum or in the case of Paralysis, benefits shall not exceed 200% of the Principal Sum.

“Loss” means, with regard to:

Loss of Use:	Total and irrecoverable Loss of Use, provided the Loss of Use is continuous for 12 consecutive months, and such Loss of Use is determined to be permanent and irrecoverable at the end of such period.
Hands and Feet:	Actual severance through or above wrist or ankle joints.
Arms and Legs:	Actual severance through or above elbow or knee joints.
Thumbs and Fingers:	Actual severance through or above metacarpophalangeal joints.
Toes:	Actual severance through or above metatarsophalangeal joints.
Sight, Speech, Hearing:	Medical certification by a duly qualified physician that such Loss of Sight, Speech and Hearing are entire and irrecoverable.
Paralysis:	Irrecoverable and permanent Loss of Use of such limbs.

Group Voluntary Accident Insurance Plan

Exposure

If, while this coverage is in force, the Insured Person is unavoidably exposed to the elements due to an accident and if, as the result of such exposure and within 365 days of the accident, the Insured Person suffers a loss which would otherwise be payable, such loss will be covered.

Disappearance

If the Insured Person disappears and the body is not found within one year and sufficient evidence is provided and confirms that the Insured Person sustained accidental bodily injury which caused his death, the Insurer will pay the Principal Sum, provided that the person or persons to whom such sum is paid shall sign an undertaking to refund such sum to the Insurer if the Insured Person is subsequently found to be living.

Additional Benefits

Any benefits payable under the additional benefits shown below are paid in addition to any other Voluntary Accidental Death and Dismemberment benefits payable, unless specifically noted otherwise.

In the event that an Insured Person is covered under two or more policies issued by the same Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person only in respect of the specific additional benefits noted with an asterisk (*) below, shall not be cumulative and shall in no event exceed the largest amount available under any one of the policies.

Repatriation Benefit*

The Insurer will pay an amount not to exceed \$10,000 for the customary and reasonable expenses incurred for preparation of the Insured Person's body for burial or cremation and transportation of the body from the place of the accident to the Insured Person's place of residence. Payment is made if, as the result of an accident, the Insured Person suffers loss of life more than 50 kilometres from his place of residence.

Rehabilitation Benefit*

When an injury which does not cause the Insured Person's loss of life results in the Insurer making a payment under the Loss Schedule, an additional amount not to exceed \$10,000 will be paid for the reasonable and necessary expenses actually incurred for the Insured Person's special training, provided (i) the Insured Person has to undergo training as the result of the injury in order to be qualified to engage in an occupation in which he would not have engaged in except for such injury, (ii) expenses are incurred within two years from the date of the accident, and (iii) no payment will be made for room or board or other ordinary living, travelling or clothing expenses.

Group Voluntary Accident Insurance Plan

Spousal Retraining Benefit*

In the event your accidental loss of life results in the Insurer making a payment under the Loss Schedule, payment is made for the reasonable and necessary expenses actually incurred within two years from the date of the accident by your Spouse who engages in a formal occupational training program, specifically qualifying him for active employment in an occupation for which he would not otherwise have had sufficient qualifications. The maximum amount payable for all such expenses shall not exceed \$10,000. No payment is made for room, board or other ordinary living, travelling or clothing expenses.

To qualify for this benefit, your Spouse shall:

- a) not be employed in a full-time occupation on the date of the accident;
- b) enroll as a full-time student in a school of higher education or vocational training for the purpose of preparing for full-time employment.

Special Education Benefit*

Should the Insured Person lose his life in an accident, the Insurer will pay, in addition to all other benefits, 5% of his Principal Sum, to a maximum of \$5,000, towards the contribution of the Insured Person's dependent Child's education. The dependent Child must be enrolled as a full-time student in any institution of higher learning beyond the Secondary School level or was at the Secondary School level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the accident.

This benefit is payable annually for a maximum of four consecutive annual payments, but only if the dependent Child continues his education.

Day Care Benefit*

In the event of the Insured Person's accidental loss of life, the Insurer will pay an amount equal to the lesser of (1) the actual cost charged by the day care centre per year, or (2) 3% of the Insured Person's Principal Sum, or (3) \$5,000 per year.

A dependent Child is eligible for this benefit if at the time of the Insured Person's accidental loss of life, is under age 13 and is currently enrolled or subsequently enrolls in an accredited day care centre within 90 days of your loss.

This benefit is payable annually for a maximum of four consecutive annual payments, but only if the dependent Child continues his enrollment in an accredited day care centre.

If at the time of the Insured Person's death, his dependent Children are not eligible for the Day Care Benefit, the Insurer will pay an amount of \$1,500 to his beneficiary.

Group Voluntary Accident Insurance Plan

Family Transportation Benefit*

If an Insured Person is injured while on a trip due to an accident which occurs more than 200 kilometres from the Insured Person's residence and is confined as an inpatient in a hospital because of such injuries and requires the personal attendance of a member of the immediate family or an authorized family representative, as recommended by the attending physician, payment is made for the expenses incurred by the family member or the authorized family representative, for accommodation and transportation to the Insured Person's bedside by the most direct route by a licensed common carrier. The maximum amount payable for such expenses will not exceed \$10,000.

Payment will not be made for board or ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle other than by a licensed common carrier, then reimbursement of transportation expenses will be limited to a maximum of \$0.30 per kilometre travelled.

"Member of the immediate family" means the Insured Person's spouse (or common-law spouse), parents, grandparents, children over age 18, brother or sister.

Seat Belt Benefit

When an injury to the Insured Person results in the Insurer making a payment under the Loss Schedule, the Insurer will increase the benefit amount payable by an additional 10%, provided that:

1. the loss occurs while the Insured Person is a passenger or driver of a private passenger type Vehicle;
2. the Seat Belt is properly fastened; and
3. verification of the actual use of the Seat Belt is part of the official report of the accident or certified by the investigating officer.

The driver of the vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the accident occurs.

"Physician" means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) licensed to practice medicine by:

1. a recognized medical licensing organization in the locale where the treatment is rendered, or
2. a governmental agency having a jurisdiction over such licensing in the locale where the treatment is rendered.

"Member of the Immediate Family" means a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the previous include natural, adopted and step relationships), spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a seat belt and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

Group Voluntary Accident Insurance Plan

“**Vehicle**” means a passenger car, self-propelled motor home, station wagon, van, jeep-type automobile or truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

Common Disaster

If injuries sustained in the same accident result in the death of both you and your insured Spouse within 90 days of such accident, the Principal Sum applicable to your Spouse will be increased up to your Principal Sum, but in no event will the amount payable under the policy exceed, in total, \$500,000.

Survivor Extended Insurance Benefit

If you die while you and your dependents are covered under this policy, the Insurer will continue the dependent coverage for a period of up to 6 months. Premium payments will be waived for this continued coverage.

The coverage continued on a dependent will be the same as that which was in effect on the date of your death. This insurance will be subject to any age reduction or termination shown in the policy at that time.

The maximum period for coverage is six months. Coverage on any dependent ceases if:

- if he or she would cease to qualify as a dependent, even if you were still alive; or
- if your surviving Spouse remarries.

Termination of the policy will have no effect on insurance continued under this benefit.

Waiver of Premium Benefit

If you are totally disabled and your life insurance is extended under a waiver of premium provision under your Group Life Insurance policy, coverage provided under this policy will also be extended and waiver of premium will be provided in accordance with the same terms and conditions as the Group Life Insurance policy.

Coverage provided for under this provision will be subject to the terms and conditions of this policy in effect as of the date of commencement of disability, including any conditions providing for reduction in amounts of insurance.

Notwithstanding anything contained in the contrary in the policy, in no event will benefits payable for any loss which occurs while coverage is being continued under this provision exceed your Principal Sum at the date of commencement of disability, less any amounts of indemnity which were payable prior to such loss as the result of the same accident.

Group Voluntary Accident Insurance Plan

Continuation of Coverage Benefit

Your coverage will continue while you are on an approved leave of absence (including maternity leave or parental leave) or lay-off (subject to payment of premiums) as outlined below:

- Approved Leave of Absence: coverage will be continued for an approved leave of absence to a maximum of 12 months from the commencement of the leave.
- Lay off: For lay off, coverage terminates at the end of the month.

Conversion

If your insurance is terminated for any reason other than non-payment of premium or attainment of age 70, you may convert your coverage to an individual policy of insurance on the form provided by the Insurer for conversion. Application for the converted policy and the initial premium must be received within 60 days of the date of termination and the effective date will be the latter of (1) the date of termination under this policy or (2) the date of application for the converted insurance.

The Principal Sum under the converted policy can be equal to or less than the combined Principal Sum under this policy and Policy 056/019808A to a maximum of \$200,000 (subject to a minimum of \$25,000). The premium for the converted policy will be the Insurer's rate in effect at the time of conversion for the Class of risk and your age. No medical evidence of insurability is required.

Exclusions

This insurance does not cover any claim arising out of bodily injury caused or contributed to by:

- a) declared or undeclared war or any act thereof or invasion;
- b) actively participating in acts of terrorism, civil commotions or riots of any kind;
- c) training, serving or taking part in any capacity in the armed forces (land, sea or air) or their operations, of any country or international authority;
- d) while serving as a pilot or crew member of any aircraft or while as a passenger in an aircraft which is being used for a purpose other than transportation;
- e) suicide or attempted suicide or intentional self-injury;
- f) injury sustained while the Insured Person is riding in, boarding or alighting from an aircraft owned or leased, by or on behalf of the Insured, or any subsidiary or affiliate of such Insured, unless specific written agreement has been obtained from the Insurer; or
- g) acts of Terrorism which involve the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s).

“Acts of terrorism” means any act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Group Voluntary Accident Insurance Plan

Payment of Benefits

The Insured Person's accidental death benefit is paid in accordance with the Insured Person's beneficiary designation on his enrollment card on file with the Insured or to the Estate if no such designation is made. Any other benefits (including those paid for your insured Spouse and/or your insured Dependent Children) are paid to you (those described in the section titled "Loss Schedule" are paid as a percentage of the Principal Sum).

Claim Procedures

To make a claim under this plan, written proof of claim must be submitted to the Insurer as outlined below:

Accidental Death Claim

If the claim is a result of an accidental death, the claim form must be submitted to the Insurer within 6 months from the date of death.

Accidental Dismemberment Claim

If the claim is for a Dismemberment benefit, the claim form must be submitted to the Insurer within 12 months from the date of the loss.

Failure to furnish proof of claim within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 12 months after first becoming eligible for accidental death benefits or 18 months for accidental dismemberment benefits.

The Insurer will provide the necessary claim forms as well as instructions covering other requirements that may aid in a prompt handling of the claim.

Disclaimer

This booklet should be kept with your Employee Handbook. It is a summary of the principal features of the plan which is governed by the terms of the Group Master Policy, 056/019809A, with the Human Resources Department. In the event of any discrepancy between this booklet and the master policy, the master policy prevails.

Underwritten by:

Certain Underwriters at
Lloyds, London through
Sutton Special Risk Inc.
33 Yonge Street, Suite 270
P.O. Box 311
Toronto, Ontario
M5E 1G4

(10/13)

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
1920 College Avenue
Regina, Saskatchewan
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Email: privacy@cooperators.ca