Sirius
Benefit Plans

Member Booklet For

Richmond Taxi Co. Ltd.

Class: All Employees
Firm Number: 45265
Group Number: 310426

This booklet represents the coverage available to members of this class. You are encouraged to review the booklet along with your certificate of coverage.

Printed: September-13

TABLE OF CONTENTS

Disclaimer

This document is for illustrative purposes only and carries no contractual or other rights.

This booklet is meant to provide information about your Group Insurance Plan. In the event of a discrepancy between this booklet and the master contract, all rights with respect to the benefits of a member will be governed by the master contract.

SECTION I

SCHEDULES OF BENEFITS

SCHEDULE OF BENEFITS

This Schedule gives you an overview of the benefits included in your group insurance plan.

Policyholder	Richmond Taxi Co. Ltd.
Class	All Employees
Effective date of this document	September 1, 2013
Life Insurance **Employee Optional Life** **Spousal Optional Life** **Short Term Disability** **Extended Health Care** **Dental Care** **Travel Assistance Insurance**	Underwritten by The Co-operators Policy Number: 8980
Second Opinion Benefit	Provided by Worldcare
Accidental Death & Dismemberment	Underwritten by Industrial Alliance Insurance and Financial Services Inc. Policy Number: 100006037
Minimum Number of Hours	All permanent employees working a minimum of 30 hours per week
Date Eligible for Insurance	After the completion of 3 months of continuous, full-time employment

Basic Life Insurance

Policy No. 8980 issued by The Co-operators

Employee Life

Amount of Insurance	1 times the annual salary
Maximum Amount of Benefit	
Non-evidence maximum	$50,000 if the participant is less than 65
Maximum with evidence	$50,000 if the participant is less than 65
Rounded	To the next $1,000 if not already a multiple thereof
Reduction of Insurance	50% at age 65
Waiver of Premiums – Elimination Period	6 months
Termination of Benefit	At the earlier of the participant's retirement or attainment of age 70

Optional Life

Amount of Insurance	A Participant and/or Spouse may select any amount of insurance from a minimum of $10,000 to a maximum of $300,000(combined with Basic Life)
Termination of Benefit	The covered person's 65th birthday

Basic AD&D Insurance

Policy No. 100006037 issued by Industrial Alliance Insurance and Financial Services Inc.

Amount of Insurance	1 times annual earning
Maximum Amount of Benefit	
Non-evidence maximum	$50,000
Maximum with evidence	$50,000
Rounded	To higher $1,000
Reduction of Insurance	50% at age 65
Termination of Benefit	At the earlier of the participant's retirement or attainment of age 70

Short Term Disability Insurance

Policy No. 8980 issued by The Co-operators

Amount of Insurance	66.67% of the gross weekly salary determined at the beginning of disability
Maximum Amount of Benefit[1]	
Non-evidence maximum	$800
Maximum with evidence	$800
Rounded	To the next highest dollar
Definition of Disability	Participant's Own Occupation
Elimination period	
In the event of accident	1st day
In the event of hospitalization	1st day
In the event of illness	8 days on a calendar basis
Maximum Benefit Period[2]	17 weeks
Taxability of Benefit	Non-Taxable
Payment Basis	Benefits are payable on a calendar day basis
Termination of Benefit	At the earlier of the participant's retirement or attainment of age 65

[1] The Maximum Amount of Benefit cannot exceed the All Source Maximum, which is 85% of net weekly salary determined at the beginning of the disability less all applicable reductions.

[2] If the participant attains age 65 during the course of such a period, the maximum benefit period for such disability may not exceed 17 weeks.

Extended Health Care

Policy No. 8980 issued by The Co-operators

Deductible per calendar year: Individual: $0 Family: $0

Coverage	Eligible Expenses / Type of Room	*Combined Maximum*	Maximum Amount Covered	% Reimbursed
Prescription Drugs				
*Prescription Drugs			unlimited	80%
Basic Health Care				
Hospital in Canada	Semi-Private		Convalescent Home – maximum of 180 days/ calendar year	80%
Out of Country Emergency Care	Maximum Trip Duration of 90 days		$5,000,000 / lifetime	100%
Paramedical Practitioner Services				
Acupuncturist			$500 / calendar year	80%
Audiologist			$500 / calendar year	80%
Chiropractor			$500 / calendar year	80%
Chiropractor X-ray				80%
Massage therapist			$500 / calendar year	80%
Naturopath			$500 / calendar year	80%
Osteopath			$500 / calendar year	80%
Physiotherapist			$500 / calendar year	80%
Podiatrist		*$500 / calendar year*		80%
Chiropodist				
Psychologist		*$500 / calendar year*		80%
Social Worker				
Speech therapist			$500 / calendar year	80%

Coverage	Eligible Expenses / Type of Room	*Combined Maximum*	Maximum Amount Covered	% Reimbursed
Other Medical Expenses				
Ambulance Services				80%
Communication Aides				80%
Hearing Aids			$600 / 48 months for all eligible services/supplies	80%
Speech Aids	Within 12 months of the accident		$1,000 / lifetime	80%
Dental Accident Coverage				80%
Diabetic Supplies				
Insulin infusion set Insulin pump accessories		$1,000 / lifetime		80%
Syringes, lancets, pen needles, blood test strips			unlimited	80%
Eye Exams			$100/ 24 consecutive months $100 / 12 consecutive months for dependents under age 22	80%
Home Nursing care			$10,000 / calendar year	80%
Laboratory Expenses			$500 / calendar year	80%
Medical Equipment				
Compression garments to treat burns			unlimited	80%
Crutches and casts			unlimited	80%
Food substitutes administered via feeding tube			unlimited	80%
*Graduated compression hose			3 pair/calendar year	80%
Splints			unlimited	80%

Coverage	Eligible Expenses / Type of Room	*Combined Maximum*	Maximum Amount Covered	% Reimbursed
Tube feeding pumps and sets			unlimited	80%
Orthopedic braces			unlimited	80%
*Orthopaedic shoes		*$400 / calendar year*		80%
*Orthotics (foot)				
Ostomy Supplies				
Irrigation sets, bags, deodorants, adhesives and creams			unlimited	80%
Catheters, catheterization supplies and urinary kits			unlimited	80%
Out-of-province medical referral			$10,000 / calendar year	100%
Oxygen and Equipment			unlimited	80%
Prosthetic Equipment				
Artificial Limbs			$25,000 / lifetime	80%
Artificial Eyes			$25,000 / lifetime	80%
External breast prosthesis			$5,000 / lifetime	80%
Surgical Bras			2 per 12 months	80%
Prosthetic socks			5 pair per year	80%

Coverage	Eligible Expenses / Type of Room	*Combined Maximum*	Maximum Amount Covered	% Reimbursed
Therapeutic Equipment Includes: Aerochamber, APNEA monitor, Blood Glucose Monitor, CPAP(Continuous Positive Airway Pressure) machine, Insulin Infusion Pumps, IPPB (Intermittent Positive Pressure Breathing) machine, TENS Unit, Traction Apparatus See the EHC section for a complete list of covered items			$1,000 / lifetime for each piece of equipment	80% 80%
Wheelchairs and Hospital Beds			$5,000 / lifetime	80%
Wig following chemotherapy			$200 / lifetime	80%
Vision Care Benefits				
Contact lenses, glasses, prescription safety glasses and prescription sunglasses.		*$200 / 24 consecutive months*		100%
Lenses post-cataract surgery			Equal to the vision care maximum	100%
Laser Eye Surgery			2 times the regular vision care benefit / once per lifetime	100%
Termination of Benefit	Age 70 or retirement, whichever is earliest			

* Physician's referral required

Please note that:

Deductible applies to all expenses except Prescription Drugs, Hospital, Vision, Out of Province Medical Referral and Out of Country Emergency Care

Generic prescription drug plan: The plan will reimburse the cost of the lowest-priced generic equivalent drug, unless the prescription states that there can be no generic substitution.

Survivor Benefit for Dependents: 2 years

Second Opinion Benefit

Provided by WorldCare

Termination of Benefit	Age 70 or retirement, whichever is earlier

Dental Care Insurance

Policy No. 8980 issued by The Co-operators

Rates based on dental procedure fee guide: province of residence

Fee guide year: Year during which expenses are incurred

The first calendar year is established as follows: 2013

Annual Dental Deductible: Individual: $0 Family: $0

Coverage	Maximum Amount Covered	% Reimbursed
Basic Dental Care Diagnostic Services Preventive Dental Care	$1,500 / insured person / calendar year	80%
Routine Dental Care Minor Restorative Services Endodontics Periodontics Rebase, Reline, Adjustment and Repair of Removable Dentures Repair of Fixed Bridges and Crowns Oral Surgery Additional Services		
Dental Restorative Services Major Restorative Services and Fixed Prosthodontics Removable Dentures Fixed Bridges		60%
Frequency of recall examinations	6 months	
Termination of Benefit	Age 70 or retirement, whichever is earliest	

Please note that:

Polishing of coronal portion of teeth: two visits per 6 months period.

Scaling and root planing: combined - 8 units every 6 months.

Topical application of fluoride: once per 6 months period, limited to children under age 21.

Pit and Fissure sealants: limited to children under age 14.

Specific and Emergency Exams: combined – 2 each benefit period

Survivor Benefit for Dependents: 2 years

SECTION II

General Information
Basic Life Insurance Benefit
Optional Life Insurance
Short Term Disability Benefits
Extended Health Care Benefits
Dental Care Benefits

GENERAL INFORMATION

Introduction

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.

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.

Who is Eligible to Enroll?

Eligibility of an Employee
To be eligible to participate in this plan you must be:

- an active employee,
- working the minimum number of hours and be a member of an eligible class, as outlined in the Schedule of Benefits in Section I,
- be eligible for insurance, based on your employment date and age, as outlined in the Schedule of Benefits in Section I, and
- insured under a provincial government health insurance plan,

Note – The age restriction shall be waived for Employees who are residents of Québec for drug coverage only, as provided under the Policy, provided the Employee is Actively at Work.

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 insurance, you and each of your dependents must be insured under a provincial government health insurance plan.

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

Spouse

- for residents of Quebec - your spouse is a person of the same or opposite sex to whom you are legally married to or engaged in a civil union with a person according to the applicable provincial legislation, or with whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse.
- for residents of all other provinces - your spouse is a person of the same or opposite sex to whom you are legally married, or with whom you have lived continually in a common-law relationship for more than 12 months and publicly represent as your spouse.

- Benefits can be extended for a former spouse where you are required by court order to provide some or all of the benefits available under your plan. Note that you can only insure one person as your spouse for all benefits at any given time.
- You must insure the same person for all spousal benefits provided under this plan.
- A change from a common-law spouse to a legal spouse is only valid when the legal spouse is living with you.

Dependent Children

- 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 22 and not working more than 30 hours a week, unless a full-time student,
  - is under age 26 and registered as a student at a college, university, trade school or similar educational facility and attending on a full-time basis, or
  - permanently incapacitated either prior to age 22 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 22 you must submit a written application within 31 days of your child reaching age 22 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 22, you must submit proof of student status annually (by completing the student declaration form).

If you are insured for Out of Country coverage under the Extended Health Care benefit (see the Schedule of Benefits in Section 1) - please note that dependents studying outside Canada are not eligible for out-of-country coverage after the first 90 days of being out of the country. It's important that you purchase alternate coverage, such as travel insurance, before your dependent student leaves Canada.

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 within 31 days of becoming eligible to join the plan.

If you enrol after the 31-day period, your application will be 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.

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.

For residents of Québec, the health evidence requirement will be waived for the purpose of drug coverage only as provided under the Extended Health Care benefit provision of the master policy.

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.

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 you are enrolled in the plan 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.

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.

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

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.

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

If you live in any other province, you have the right to name a beneficiary at the time you apply for insurance and you can change your beneficiary at any time, where permitted by law, by completing a form available from your employer/plan administrator. If your beneficiary dies before you do or if you do not name a beneficiary, payment will be made to your estate. If your beneficiary is a minor, payment will be made to the trustee (if you named one) or a public trustee (if you have not appointed a trustee for minor beneficiaries). A beneficiary named under the basic life benefit is, unless stipulated to the contrary, the beneficiary for all coverages under your plan.

What am I insured for?

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

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:

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.

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, exclusive of bonuses, 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 36 month period. If you have been employed less than 36 months, it will be averaged over the length of time employed.

Excluded earnings:
In all of the above instances, bonuses, 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 Québec 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.

Termination of Coverage

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
- the end of a period for which premiums 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
- for residents of Quebec - on the date you reach the applicable termination age specified in the Schedule of Benefits, however, for the purpose of drug coverage only as provided under the Extended Health Care benefit, the termination age will be waived provided you are Actively at Work; or
- the date of termination of your employer's group policy.

Note: if you live in Québec and cease to be Actively Employed as a result of a strike, work stoppage or lock-out, your drug coverage may be extended for 30 days from the date you ceased to be Actively at Work.

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 have been paid for dependent coverage.

Claiming Benefits

Where do I find a claim form?

Claim forms are available from your employer, plan administrator or from the Sirius Benefit Plans website www.siriusbenefits.ca and click on *Forms*. All claim forms must be correctly completed, dated and signed. To avoid delays, always include your full name, the group, firm and certificate numbers 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.

General Provisions

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.

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 before any benefits will be paid. The reimbursement agreement outlines the terms for reimbursing paid expenses 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 before settling any claim with the third party.

Life Insurance Conversion Privilege

"Life Insurance" for residents of Quebec, shall mean the Amount of Life Insurance inforce for each Covered Person under this Policy insured for the following benefits: Basic Life Insurance, Optional Life Insurance, Dependent Optional Life Insurance and Dependent Life.

"Life Insurance" for residents of all other Provinces, shall mean the Amount of Life Insurance inforce for each Covered Person under this Policy insured for the following benefits: Basic Life Insurance and Optional Life Insurance.

Where the Covered Person's Life Insurance under this Policy terminates before age 65, the Covered Person 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.

For residents of Quebec for Dependent Life conversion - The minimum Amount of Insurance to be converted for an Employee is $10,000 and the minimum Amount of Insurance to be converted for an eligible Dependent is $5,000. The minimum Amount of Insurance allowed to be converted to a Permanent Traditional Plan is $5,000, and the minimum Amount of Insurance allowed to be converted to a Term to age 65 plan or a One Year non-renewable Term Plan is $10,000.

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

Amount of Insurance
Where your or your spouse's insurance 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:

- $400,000 for residents of Quebec or $200,000 for residents of all other Provinces, 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) die 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 and Sirius Benefit Plans are under no obligation to advise any person of their right to convert.

BASIC LIFE INSURANCE BENEFIT

Policy No. 8980 issued by The Co-operators

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 Amount of Insurance 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 shown in the Schedule of Benefits, your basic group life insurance may be increased to an amount not exceeding the Maximum with Evidence shown in the Schedule of Benefits, provided evidence of good health is approved in writing by Co-operators Life.

What if I become terminally ill?

The living assistance benefit may be available to you as an advance payment of your basic life insurance to help meet your medical or other health and welfare expenses if you become terminally ill and have been approved for the total disability life waiver of premium. Your employer must approve your application for this benefit and Co-operators Life must review to determine if 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.

If you become totally disabled (as defined in the policy) prior to age 65, your life insurance coverage will continue until the earlier of; your 65th birthday or your recovery, retirement or death.

Satisfactory proof of your total disability must be submitted to Co-operators Life within 6 months from the date of total disability and thereafter when requested by Co-operators Life.

Premiums due under this benefit will be waived after 6 months of total disability, or if you are insured under the Long Term Disability Benefit through Co-operators Life, premiums will be waived once you begin receiving monthly payments under that benefit. The life waiver of premium benefit terminates at age 65.

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.

OPTIONAL LIFE INSURANCE

Policy No. 8980 issued by The Co-operators

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.

SHORT TERM DISABILITY BENEFITS

Policy No 8980 issued by The Co-operators

What am I insured for?

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

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

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

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.

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 Short Term Disability Benefits

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 a 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 weekly benefit effective the day following the completion of the elimination period and payable for the maximum number of weeks as indicated in the Schedule of Benefits as the benefit period.

When will benefits begin?
Your benefits will begin the day following the end of the elimination period indicated in the Schedule of Benefits. The elimination period refers to the time frame of total disability, which must be satisfied before you qualify to make a claim for benefits. Benefits are not payable and premiums are not waived during this period.

How long will benefits be paid?
Your Benefit Period will not continue past the number of weeks from the disability date, as indicated in the Schedule of Benefits.

The Benefit Period is:

- the period of time after the elimination period during which you are continuously totally disabled, and
- if the disability is not continuous, any period of time during which the disability is considered to be a recurrence.

Recurrence of Total Disability

If you were paid Short Term Disability Benefits and you return to work for less than 4 weeks and make a claim for the renewal of benefits due to a recurrence of the same or a related injury or sickness, your disability will be deemed a continuation of your previous disability.

Benefits are pro-rated for partial weeks
Short Term Disability Benefits payable for periods less than a full week will be paid 1/7th of the applicable Weekly Benefit for each day of the disability.

Are my benefits taxable?
Where you and all of the other employees in your class pay the full premium for the Short Term Disability coverage, the Weekly Benefit will be non-taxable. The tax status is stated 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 any or all of: rehabilitation assessment, and/or rehabilitative employment, and/or rehabilitative treatment, and/or rehabilitation services. The services and length of the program must be recommended and approved by Co-operators Life.

Approval of Rehabilitation Program
Co-operators Life will decide whether or not a rehabilitation program is appropriate and/or whether it will be provided for any employee.

Once the rehabilitation program is approved, Co-operators Life may issue, if eligible, weekly 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 indemnity benefit payment period unless an extension of the duration is recommended and approved in writing by Co-operators Life.

Calculation of Weekly Benefits during a Rehabilitation Employment period
Where you participate in Rehabilitative Employment approved by Co-operators Life, the applicable Weekly 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 Short Term Disability benefits are taxable.

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

Termination of Benefits

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

Benefit Reductions

What reductions occur when determining my Short Term Disability Benefit payment?

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

Your net salary is your gross salary minus involuntary deductions for federal and provincial income tax, Employment Insurance premiums (EI) and Canada/Québec Pension Plan contributions. For taxable Short Term Disability plans, the amount of your taxable benefit will be limited to the lesser of the amount of insurance for which you are covered or 85% of your pre-disability gross weekly salary.

All Source Compensation - Direct Reductions
Your Short Term Disability benefit payable 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 Québec 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.

All Source Compensation - Indirect Reductions
Your benefit will be further reduced if the total of the following All Source Compensation and your weekly benefit exceeds 85% of your pre-disability gross weekly salary for taxable plans, your net weekly salary for non-taxable plans. If it does, your Short Term Disability benefit will be reduced by the amount in excess of 85% 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 Short Term Disability 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 Weekly Benefit

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

Repayment of Benefits

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

Total Disability Waiver of Premium

If you are also insured for long term disability benefits and your claim for long term disability benefits is approved, premiums for your short term disability benefits will be waived effective the same date as the premiums for your long term disability benefits are eligible to be waived.

If you are not insured for long term disability coverage under the policy but are insured for basic life insurance benefits under the policy and your claim for total disability life waiver of premium benefits is approved, Co-operators Life will waive your short term disability benefit premiums. The short term disability premium waiver will commence with the first premium due after your basic life waiver of premium is approved.

When do my Short Term Disability Benefits Terminate?

No Short Term Disability Benefits will be paid beyond:

- the number of weeks as indicated in the Schedule of Benefits, or
- the date you cease to be totally disabled, or
- the date you begin working in any occupation, except as provided for under the rehabilitation program, or
- the date you reach the termination age as indicated in the Schedule of Benefits. However, if you are totally disabled on this date, you will, subject to satisfying any other conditions in the policy, be entitled to a maximum of 15 weeks of Short Term Disability benefit payments after the completion of the elimination period, 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 Short Term Disability 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
- on any leave of absence including maternity leave or parental leave except for as provided below:

Maternity and Parental Leave
If you become totally disabled while on maternity or parental leave, 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 is deemed to commence on the date agreed upon by you and your employer and end on the date you were scheduled to return to active work. If a child is born prior to the date upon which your maternity leave is scheduled to commence, the leave is deemed to commence on the date of birth.

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

What limitations are there on STD benefits?
No Short Term Disability Benefits will be payable for any period of total disability resulting directly or indirectly from any of the following:
- 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, oruse 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
- medical care which is cosmetic in nature and not required due to an injury or sickness, or
- any injury or sickness for which a third party is, or may legally be liable, except as provided for under the third party liability provision in the policy, or
- medical care which is not medically necessary to treat an injury or sickness, except for as provided below:
  - periods of total disability due to medical care that is not medically necessary may be eligible for Short Term Disability benefits if the period of disability extends beyond 14 days from the initial date of disability. Weekly benefits will be payable commencing on the 15th day of disability.
  - periods of total disability due to the donation of an organ or tissue will be considered as necessary medical care.

When and how to submit a STD claim

Co-operators Life must receive written notice of a claim for Short Term Disability benefits within 30 days from the end of the elimination period.

Failure to furnish proof within this time will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible, but in no event will this be more than 90 days from the end of the elimination period.

EXTENDED HEALTH CARE BENEFITS

Policy No. 8980 issued by The Co-operators

What am I insured for?

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

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.

* this does not apply to drugs listed on the Regie de l'assurance-maladie du Quebec basic drug formulary for any covered person who resides in Quebec

Co-insurance Levels and Deductible Amounts

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

The deductible amounts are shown in the Schedule of Benefits. 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.

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.

Covered Extended Health Care Services and Supplies:

To qualify for coverage the covered person (you and your insured 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 Sirius Benefit Plans for consideration.

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.

(ii) extemporaneous preparations or compound mixtures must contain at least one active prescription by law ingredient in a therapeutic concentration that is considered an eligible prescription drug under this provision. No benefits are payable for the following extemporaneous preparations or compound mixtures:
   1. drug compounds used primarily for cosmetic purposes;
   2. compounded medications which are similar to a commercially available pre-manufactured drug.

(iii) life sustaining drugs that do not require a prescription by law are covered if:
   1. they are prescribed by a health care provider legally licensed to do so within the province; and
   2. life sustaining drugs include, but are not limited to: insulin, diabetic test strips, disposable insulin needles and syringes.

(iv) Oral and non-oral contraceptives, including IUDs, requiring a prescription from a physician.

Any drug categorized as acute will be covered up to a 34 day supply and maintenance drugs will be covered up to 100 day supply. All drugs will be limited to the lowest priced generic equivalent unless otherwise indicated in the Schedule of Benefits.

For residents of Québec, in addition to the prescription drug coverage described in this section, benefits are also provided for eligible drugs and supplies listed in the current Québec Liste de medicaments published by la Regie de l'assurance-maladie as filed with Co-operators Life.

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.
- charges for any prescription drugs beyond the maximum dosage/quantity for a covered person's course of treatment.
- drugs dispensed by a physician, dentist or clinic or by a non-accredited hospital pharmacy.
- drugs dispensed during treatment as an in-patient or an out-patient in an approved hospital.
- drugs that are considered cosmetic, such as topical minoxidil for hair loss or sunscreens, whether or not prescribed for a medical reason.
- fees for the administration of any injectable drugs, including but not limited to serums, vaccines, vitamins, insulin, and allergy extracts.
- allergy serums, health foods, most vitamins, vaccines, nutritional supplements, growth hormones, homeopathic, naturopathic or herbal drugs, lozenges, dental products and mouthwashes.
- drugs prescribed for the treatment of erectile dysfunction, infertility, obesity or smoking cessation whether or not prescribed for a medical reason, unless otherwise indicated as covered in the Schedule of Benefits.
- drugs which would have been payable by the provincial plan if proper application had been made.

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

For Employees who are residents of Québec, for the purpose of drug coverage only - the maximum benefit payable per Covered Person for each twelve (12) months of coverage shall be unlimited. The maximum out-of-pocket maximum contribution per covered adult is determined by la Regie de l'assurance-maladie including any co-insurance or deductible amounts. After the Covered Person has reached the out-of pocket maximum, covered RAMQ drugs will be reimbursed at 100% co-insurance.

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

No benefits will be paid for hospital 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 is not covered care under this plan.

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

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 3 or more days of confinement in an approved hospital for a medically diagnosed condition that required acute care.

Co-operators Life covers the difference between the convalescent hospital's standard ward rate and the hospital accommodation shown in the Schedule of Benefits. For out-of-province 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 30 days during which no approved hospital or convalescent hospital confinement was required, or
- it is required for a medically diagnosed condition unrelated to the conditions for which benefits have already been paid.

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

Out-of-Country Emergency Care
Out-of-Country Emergency care is provided 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.
- Ambulance services include air ambulance, by a licensed ambulance company to the nearest centre where essential treatment is available.
- Dental accident treatment if it would have been covered under 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.

The following additional travel benefits are provided if:

- the loss is a covered out-of-country or out-of-province Medical Emergency or
- the loss is a covered Medical Emergency that occurred within the covered persons province of residence at a location in excess of 500 kilometres from the covered person's home.

Expenses incurred out of Canada, accumulate to the Emergency Out-of-Canada maximum as indicated in the Schedule of Benefits. Expenses incurred in Canada, accumulate to the overall Extended Health Care maximum as indicated in the Schedule of Benefits.

- Emergency Medical Transportation - coverage is provided for emergency medical transportation to the nearest hospital where treatment is available. If the covered person is travelling outside Canada, coverage is also provided for the cost of emergency medical transportation to a hospital in Canada when the covered person is assessed as medically transportable, provided transportation has been pre-approved and arranged by Co-operators Life.
- Qualified Medical Attendant - reasonable fees, including airfare, accommodation, and meal expenses, charged by a medical attendant other than a relative who accompanies the covered person during a return flight on a commercial airline, when required by the attending physician and when pre-approved and arranged by Co-operators Life.
- Return of Family Members – in the event that arrangements for pre-paid transportation to the covered person's province of residence were missed due to a covered Injury or Sickness, the cost of one-way economy fares, less any credit for unused tickets, for the covered person and dependents. In addition, when the covered person is transported by air ambulance or commercial stretcher, one-way economy airfare to return the dependents home, provided travel is pre-approved and arranged by Co-operators Life. Reasonable and customary expenses, including return or round-trip economy class airfare, for an escort to accompany dependent children home, when necessary and when pre-approved by Co-operators Life.
- Bedside Attendance - reimbursement for round-trip economy airfare by the most direct route via a common carrier in the event that the covered person becomes hospitalized as a result of a covered injury or sickness, if the attending physician advises that the covered person requires the attendance of a family member or close friend.
- Return of Vehicle – reimbursement of the reasonable and customary amount to a maximum of $3,000 for a commercial agency to return a vehicle to the covered person's home or, if a rental vehicle was used, to the nearest rental agency, in the event that the covered person is unable, for reasons of a covered illness or injury, to return home with the vehicle used for the journey, or:
- If the covered person was air evacuated, reimbursement of the cost for one-way economy class airfare to the city from which an air evacuation commenced in order to retrieve the vehicle. If the covered person was air evacuated with another covered person, then that person is also eligible for one-way economy class airfare to the city from which the air evacuation commenced. Reimbursement is limited to a combined maximum of $3,000.
- Out-of-Pocket Allowance - reimbursement up to a maximum of $2,500 for reasonable and customary living expenses, child care, essential telephone calls and taxi fares incurred by the covered person or by persons remaining with the covered person while the covered person is hospitalised as an inpatient.
- Repatriation Expenses - in the event that a covered person dies from a covered injury or sickness, Co-operators will pay up to a maximum of $10,000 for:
  - cremation expenses at the place of death, or
  - Reasonable and customary expenses incurred in preparing the deceased for burial and shipment to the province of residence provided the deceased does not have any other Repatriation benefit under the policy or any other insurance policy. (No reimbursement is provided for the cost of the casket.)
- Identification of Deceased – in the event that a covered person dies from a covered injury or sickness while travelling alone and if required by authorities, reimbursement of round-trip economy airfare by the most direct route via a common carrier for a family member to travel to identify the deceased prior to release of the body. If you are travelling alone, we recommend that you register with the Canadian embassy in the country you are visiting.

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.

Paramedical Practitioners Services

Reasonable and Customary Expenses 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.

- Acupuncturist
- Audiologist
- Chiropractor – x-rays also covered
- Massage Therapist
- Naturopath
- Osteopath
- Physiotherapist
- Podiatrist/Chiropodist
- Psychologist/Social Workers
- Speech Therapist

Other Medical Services

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.

Communication Aids

The following communication aids are covered:

- Hearing aids, including repairs. Hearing aid batteries, tubing and ear molds provided at the time the hearing aid is purchased are covered. The maximum amount payable is indicated in the Schedule of Benefits.
- Speech aids, such as bliss boards and laryngeal speaking aids, when no alternative method of communication is possible. The maximum amount payable in a covered persons' lifetime is indicated in the Schedule of Benefits.

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 insured for this coverage, and
- treatment starts within 100 Days after the accident. This requirement is waived if a diagnosed medical condition delays treatment beyond 100 Days.

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.

Diabetic Supplies

The following diabetic supplies are covered to the maximum indicated in the schedule of benefits:

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

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

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.

Home Nursing Care

Nursing care is covered if:

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

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

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 does not normally reside in the Covered Person's home and is not a member of the Covered Person's family.

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

The maximum amount payable is shown in the Schedule of Benefits.

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.

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

A pre-determination of benefits is an assessment 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, we will then advise you of the coverage that will be provided. The insurer 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 plan.

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. The maximum is indicated in the Schedule of Benefits.

Medical Equipment
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.

The initial charges for the following medical equipment required as a result of a medically diagnosed condition:
- Crutches, casts, trusses, walkers and canes.
- Compression garments to treat burns.
- Graduated compression hose, to the maximum indicated in the Schedule of Benefits.
- Food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.
- Splints, including shoes attached to a splint. Intra-oral splints are not covered.
- Orthopedic braces. Braces are wearable, orthopedic appliances that rely on a rigid material such as metal or hard plastic to hold parts of the body in the correct position. Elastic supports and foot orthotics are not considered braces. Dental braces are not considered a covered Extended Health Care expense.
- Mist tents and Nebulizers (excluding humidifiers and vaporizers)

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.

Orthopedic shoes and/or foot orthotics must be:
- prescribed by a physician or foot specialist (e.g. podiatrist or chiropodist), and
- custom-made and dispensed by an orthotist, pedorthist, podiatrist or chiropodist.

For each claim or predetermination, the Covered Person is required to supply Co-operators Life with the following:
- a detailed prescription (referral) from the prescribing Physician or foot Specialist
- a diagnosis of the condition, the biomechanical evaluation, gait analysis, description of the casting technique and the original receipt from the recognized provider.

Ostomy Supplies
The following colostomy and ileostomy supplies are covered:
- Irrigation sets, bags, deodorants, adhesives and skin creams.
- Charges for catheters, catheterization supplies and urinary kits are also covered under this provision.

Out-of-province medical referral
For insureds covered by the health and hospitalization insurance plan of their province of residence, expenses incurred outside the province of residence for the following treatment, services, products and articles are covered, provided that such expenses are pre-approved by the insured's provincial health and hospitalization insurance plan and by Co-operators Life:

- hospitalization in a hospital where the insured receives curative treatment;
- professional fees of a physician for medical, surgical or anaesthetic care other than fees for dental care;
- transportation and accommodation expenses paid by the insured;
- expenses incurred for medications, x-rays and laboratory analysis.

The plan will reimburse the difference between the expenses incurred and the benefits payable under the insured's provincial health and hospitalization insurance plan or by any other public plan that has an agreement with the insured's province of residence in Canada.

Before incurring any expenses for this product or care, prior approval is required. Please forward all relevant medical information obtained from your attending medical physician to Sirius Benefit Plans for assessment.

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

Prosthetic Equipment
Charges for the following standard prosthetic equipment are covered to the maximum amount per piece of equipment payable as indicated in the Schedule of Benefits:

- Artificial limbs, including repairs.
- Artificial eyes, including rebuilding and polishing of artificial eyes.
- External breast prostheses (mastectomy forms) and surgical bras.
- Prosthetic socks, as indicated in the Schedule of Benefits.

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.

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

- diabetic administration equipment (insulin infusion pumps)
- diabetic blood glucose monitoring equipment (BGM machines)
- intermittent positive pressure breathing machine (IPPB)
- continuous positive airway pressure machine (CPAP)
- transcutaneous nerve stimulator (TENS)
- cervical collar
- aerosol equipment.
- traction apparatus
- enuresis alarm (formerly referred to as a mozes detector)
- apnea monitor for respiratory dysrhythmia
- peak flow meter
- aerochambers
- chest percussors, drainage boards and sputum stands
- tracheostoma tubes
- suction pumps

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

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 following chemotherapy. The maximum amount payable in a covered person's lifetime is indicated in the Schedule of Benefits.

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

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

The maximum benefit payable to each covered person is indicated in the Schedule of Benefits. There is no coverage for any service or supply which does not provide for the correction of one's vision except when eyeglasses or contact lenses are prescribed by a licensed optometrist or ophthalmologist following eye surgery.

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, without payment of premiums, for the number of years as indicated in the Schedule of Benefits, provided this benefit remains in force under the master policy 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 policy.

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 any worker's compensation act or similar statute or a third party or where the covered person is entitled to without charge or for which a charge is made only because the covered person has insurance coverage.
- Services or supplies that do not represent reasonable and customary treatment of the covered person's medically diagnosed condition.
- Services or supplies associated with:
  - treatment performed for cosmetic purposes only;
  - recreation or sports rather than with other regular daily living activities;
  - anti-obesity treatment, unless otherwise indicated in the Schedule of Benefits;
  - protein and dietary supplements whether or not prescribed for a medical reason however, food substitutes that can only be administered through a tube feeding process are covered.
  - the diagnosis or treatment of infertility, unless otherwise indicated in the Schedule of Benefits;
  - contraception, other than contraceptive drugs.
- Services or supplies or expenses:
  - not specifically listed as a covered expense, or
  - associated with covered items, unless specifically listed as a covered expense.
- Services or supplies received outside Canada except as provided under the Emergency Out-of-Canada provision.
- Expenses incurred for:
  - the completion of claim forms,
  - obtaining further medical information regarding claims for covered expenses,
  - medical screening or examinations for the use of a Third Party, or
  - 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 expenses incurred as a result of a situation from injuries sustained in, or directly or indirectly from, a vehicle accident where the covered person was driving a vehicle involved in the accident and had either:
  - alcohol in his or her blood in excess of 80 milligrams of alcohol per hundred millilitres of blood, or
  - his or her capacity impaired as a result of drug or alcohol usage.

Is pre-determination of certain benefits necessary?
We recommend that if extended health care are likely to exceed $400, a detailed treatment plan should be submitted before the treatment begins. This procedure will identify the cost you may be responsible for and will provide you with an opportunity to seek an alternative course of treatment, if necessary. In order for benefits to be paid, you must be eligible for coverage on the date the expense is actually incurred.

Co-ordination of Extended Health Benefits
Benefits will be coordinated 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 coordinated 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 the plan. Government plans are plans that are legislated, funded, or administered by a government. This does not apply to drugs listed on the Regie de l'assurance-maladie du Quebec basic drug formulary for any covered person who resides in Quebec.

When and how to submit an EHC claim
You must submit notice of a claim for extended health care benefits within 12 months from the date the expense was incurred. If the policy 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

Policy No. 8980 issued by The Co-operators

What am I insured for?

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

You will be reimbursed for incurred allowable expenses, subject to the deductible, co-insurance 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 participant resides. 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 the insurer.

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.

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-insurance as the covered dental procedure and will not exceed the reasonable and customary amount of the eligible dentist's fee.

Co-insurance Levels, Deductible Amounts and Maximums

Allowable expenses are reimbursed at the co-insurance 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.

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. Orthodontic expenses (if indicated as covered in the Schedule of Benefits) 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 covered to the frequency limits indicated in the Schedule of Benefits
- A complete dental examination is covered once per lifetime with any one particular dentist or once in a 36 month period if the dentist is changed.
- Full mouth or complete series x-rays are covered once in a 36 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 36 month period.
- Cleaning of the teeth is covered as indicated in the Schedule of Benefits.
- Fluoride application to the teeth is covered as indicated in the Schedule of Benefits.
- Procedures for the extraction of teeth and their roots, including pre and post-operative care. No benefits are payable for any additional charge for the removal of sutures in connection with any dental treatment.
- Non-bonded amalgam (silver) and tooth coloured fillings on both front and back teeth for restoring the natural tooth surfaces. Stainless steel crowns for the restoration of dependent children's teeth are also covered. If bonded amalgams are performed, expenses will be limited to the cost of non-bonded amalgams.
- Simple space maintainers, for Children under 19, for keeping the space of a lost baby tooth until the permanent tooth comes in.
- Oral hygiene instruction is covered once per lifetime.
- Denture repairs are covered. The resetting and relining of removable denture teeth are covered once every 36 months. Addition of teeth to a denture is covered provided the additional teeth are required to replace teeth that were lost, extracted or fractured after the effective date of the covered person's coverage under this plan. Denture cleaning and polishing charges are not covered.
- Filing the surfaces (edges) of the teeth (interproximal discing).
- Pit and fissure sealants are covered as indicated in the Schedule of Benefits.
- Caries and pain control procedures are covered only when performed on a day separate from any other restorative procedure.
- Desensitization of teeth and pulp mummification will not be covered as a separate procedure code.
- Minor surgical procedures, simple extractions and post-surgical care. Complicated extractions including impacted and residual roots are also covered. Reasonable and customary expenses for anaesthesia in conjunction with covered surgical procedures are covered. Any charges for facility fees or other related expenses are not covered.

Level 2 – Minor Restorative Endodontic and Periodontic Services

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.

Periodontics - treatment of the soft tissue (gums)

- Scaling, root planing and occlusal adjustment and equilibration are covered as indicated in the Schedule of Benefits.
- Periodontal surgery is limited to 4 sites per calendar year with one surgical procedure per site. Reasonable and customary expenses are payable for anaesthetic when required in conjunction with covered periodontal or oral surgery. Any charges for facility fees or other related expenses are not covered.
- Periodontal appliance coverage must be approved by the dental consultant.

Level 3 - Major Restorative Covered Services

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 a silver amalgam and plastics to adequately restore the tooth.

Crowns and 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.
- Veneers, composite or porcelain, whether lab processed or not, must be referred to the dental consultant for approval.
- Posts, cores, pins and copings related to covered crowns.
- Repairs to covered tooth-coloured materials.
- Removal and recementation of crowns and onlays.

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

No benefits will be paid for:

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

Dentures and Bridgework

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.

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

Replacement appliances are also covered when:

- The existing appliance is temporary - the amount reimbursed for the temporary appliance will be deducted from the cost of the permanent appliance.
- The existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the covered person is 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.

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, without payment of premiums, for the number of years as indicated in the Schedule of Benefits, provided this benefit remains in force under the master policy 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 policy.

Dental Care General Limitations

No Dental Benefits will be paid for:

- Services or supplies not specifically listed as covered.
- Services or supplies that do not represent reasonable treatment.
- Procedures, appliances or restorations used to increase vertical dimension, repair or restore teeth damaged or worn due to attrition or vertical wear.
- For implants and any implant-related treatment or prosthesis.
- 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.
- 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 or dental plaque control,
  - ⇨ oral hygiene instruction, unless indicated as covered in the Schedule of Benefits,
  - ⇨ treatment planning,
  - ⇨ completion of claim forms or pre-determinations,
  - ⇨ consultations, other than with specialists, and
  - ⇨ travel expenses, broken appointments or communication costs.

Is pre-determination of certain benefits necessary?

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

Co-ordination of Dental Care Benefits

Benefits will be co-ordinated 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 the plan. Government plans are plans that are legislated, funded, or administered by a government. This does not apply to drugs listed on the Regie de l'assurance-maladie du Quebec basic drug formulary for any covered person who resides in Quebec.

When and how to submit a Dental claim

You must submit 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 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 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. This extension of benefits does not apply in the case where orthodontic coverage has terminated only because the Child has attained the age indicated in the Schedule of Benefits.

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

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
S4P 1C4
Email: privacy@cooperators.ca

SECTION III

Basic AD&D Insurance
Second Opinion Benefit

BASIC A.D.&D. INSURANCE

Policy No. 100006037 issued by Industrial Alliance Insurance and Financial Services Inc.

Coverage

Any accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

Eligibility

You are eligible if you are an employee of a participating employer of the Policyholder, are under age 70 or the age provided in the participating employer's Group Life policy, and are insured under the participating employer's Group Life policy.

Amount of Insurance

Your amount of insurance (Principal Sum) is an amount equal to the amount of Basic Group Life Insurance in effect under the participating employer's current Group Life policy with the Policyholder, or its replacement, subject to a minimum of $15,000.00 to a maximum Principal Sum of $500,000.00.

Benefits

Accidental Death, Dismemberment and Specific Loss Indemnity

The policy provides benefits for Injury resulting in Loss of, **or permanent and total Loss of Use of**, which occurs within **12 months** after the date of the accident as follows:

Life	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and the Entire Sight of One Eye	The Principal Sum
One Foot and the Entire Sight of One Eye	The Principal Sum
Speech and Hearing in Both Ears	Three-Quarters of the Principal Sum
One Arm	Three-Quarters of the Principal Sum
One Leg	Two-Thirds of the Principal Sum
One Hand	Two-Thirds of the Principal Sum
One Foot	Two-Thirds of the Principal Sum
Entire Sight of One Eye	Two Thirds of the Principal Sum
Speech or Hearing in Both Ears	One-Third of the Principal Sum
Thumb and Index Finger of Either Hand	One-Third of the Principal Sum
Four Fingers of Either Hand	One-Third of the Principal Sum
Hearing in One Ear	One-Third of the Principal Sum
All Toes of One Foot	One-Third of the Principal Sum

Paralysis Benefits

Quadriplegia (complete paralysis of both upper and lower limbs).	Two Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs)	Two Times the Principal Sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	Two Times the Principal Sum

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one accident will not exceed the following:

(a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;
(b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same accident.

"Injury" whenever used in the policy means bodily injury caused by an accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

"Loss" whenever used in the policy with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

Bereavement Benefit
If Injury results in the loss of your life, the Company will pay the reasonable and necessary expenses actually incurred by your Spouse and Dependent Children for up to six sessions of grief counselling, by a professional counsellor, subject to a maximum of $1,000.00.

Continuation of Coverage
Coverage under the policy may be continued during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave, provided payment of premium is continued.

Conversion Option
In the event of the termination of your insurance for any reason, you may, within 31 days following the date of such termination, make written application to the Company for an individual Accidental Death and Dismemberment policy not to exceed the amount of insurance in force under all policies issued or $500,000.00.

Critical Disease Benefit
If, prior to age 65, you are diagnosed by a specialist with a Covered Disease and you are totally disabled from the Covered Disease for at least nine months following the date of diagnosis, the Company will pay 10% of your Principal Sum up to a maximum of $50,000.00.

"Covered Disease" means Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Huntington's Chorea, Multiple Sclerosis, Necrotizing Fasciitis, Parkinson's Disease, Peripheral Vascular Disease, Poliomyelitis and Type 1 Diabetes (Insulin Dependent).

Day Care Benefit
If Injury results in the loss of your life within 12 months of the date of the accident, the Company will pay five percent of your Principal Sum to a maximum of $5,000.00 for each year your Dependent Child is enrolled in a legally licensed Day Care (not to exceed four years) for each of your Dependent Children who are under 13 years of age and are enrolled in a legally licensed Day Care Centre on the date of the accident or are enrolled in a legally licensed Day Care Centre within 12 months after your death.

Education Benefit
If Injury results in your loss of life, the Company will pay, in addition to all other benefits, five percent of your Principal Sum to a maximum of $5,000.00 to your Dependent Child, who on the date of the accident was enrolled as a full-time student in any institution of higher learning above the secondary school level, or was enrolled as a full-time student at the secondary school level and enrolls as a full-time student in any institution of higher learning within 12 months after your death, but not to exceed four consecutive annual payments.

Family Transportation Benefit
When, as a result of Loss covered by the policy, you are confined as an inpatient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the Company will pay the reasonable expenses actually incurred by any member of your immediate family for hotel accommodation and transportation by the most direct route to you, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Funeral Expense Benefit
If Injury results in your loss of life, the Company will pay the reasonable and necessary funeral expenses actually incurred, subject to a maximum of $1,000.00.

Home Alteration and Vehicle Modification Benefit
In the event you sustain a Loss for which indemnity becomes payable under the part titled "Accidental Death, Dismemberment and Specific Loss Indemnity" and subsequently require the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to your principal residence and/or the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $15,000.00.

Identification Benefit
If Injury results in the loss of your life and identification of your body by a member of your immediate family is required by the police or a similar law enforcement agency and your body is located not less than 150 kilometers from said member's normal place of residence, the Company will reimburse the reasonable and necessary expenses actually incurred by such member for transportation and hotel accommodation to a maximum of $5,000.00.

In-Hospital Indemnity Benefit
In the event you sustain an Injury which results in confinement within a hospital as a resident in-patient for more than five consecutive days, the Company will pay (a) a monthly benefit of one percent of your Principal Sum; or (b) for periods of less than one month, one thirtieth of the above monthly benefit per day, subject to a monthly maximum of $1,000.00. Benefits are retroactive to the first day of hospital confinement.

Rehabilitation Benefit
If Injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the Company will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum amount of $15,000.00 as the result of any one accident.

Repatriation Benefit
If Injury results in your loss of life, the Company will pay the actual expense incurred for preparing your body for burial or cremation and shipment to your city of residence, subject to a maximum amount of $15,000.00.

Seat Belt Benefit
In the event you sustain an Injury which results in a Loss payable under "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy, your amount of Principal Sum will be increased by 10% if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit
In the event you lose your life as the result of an Injury, the Company will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Waiver of Premium
In the event you become totally disabled and your waiver of premium claim is accepted and approved under the Policyholder's current Group Life policy, then premiums payable under the policy will be waived as of the same date the claim is accepted and approved by the Group Life policy Underwriter.

Exposure and Disappearance
If due to accident you are unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident you suffer a Loss for which indemnity would otherwise have been payable hereunder, such Loss shall be deemed to be the result of Injury as defined herein.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

Aggregate Limit of Indemnity
The policy is subject to an Aggregate Limit of Indemnity of $5,000,000.00 for all losses resulting from any one aircraft accident. This means that in the event of an aircraft accident that results in an accumulation of losses exceeding $5,000,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

Exclusions

Cover does not apply to any loss caused or contributed to by:

- flying as a pilot or crew member in any aircraft;
- suicide or self-destruction;
- full-time, active service in the armed forces;
- war or act of war;
- flying in owned, operated or leased aircraft of the Policyholder;
- operating a motor vehicle either while under the influence of any intoxicant or if the Insured Person's blood contains more than 80 milligrams of alcohol per 100 milliliters of blood.

Beneficiary

The beneficiary or beneficiaries of an Insured Person shall be that person or those persons designated by the Insured Person under the Policyholder's current Group Life policy. If no such designation has been filed, the beneficiary in respect of loss of life of an Insured Person shall be the estate of the Insured Person. All other indemnities payable will be payable to the Insured Person except indemnities payable under "Bereavement Benefit", "Day Care Benefit", "Education Benefit", "Family Transportation Benefit", "Identification Benefit" and "Spousal Retraining Benefit".

A.D.&D. Claims Procedures

Claim forms are available from your plan administrator or from Sirius Benefit Plans. Industrial Alliance reserves the right to request additional information when processing the claim.

Written notice of accidental death, dismemberment, loss of sight, hearing, paralysis, loss of use of limbs or onset of critical disease is to be given to Industrial Alliance within a period of 30 days from the date of the accident or the date of diagnosis.

For all other claims, completed claim forms must be filed with Industrial Alliance within 90 days after the date of the Injury and no later than 12 months regardless of whether expenses have been incurred.

SECOND OPINION BENEFIT

Benefit provided by Worldcare

Coverage

This benefit is available to you and any eligible dependent covered under the Extended Health Care benefit. This benefit provides independent second medical opinions from physicians at leading U.S. hospitals.

Eligible Medical Conditions

You and your eligible dependents are entitled to receive WorldCare Second Opinions for the following conditions:

- AIDS
- ALS
- Alzheimer's disease
- Amputation
- Any life threatening illness
- Benign brain tumor
- Cancer
- Cardiovascular conditions
- Chronic pelvic pain
- Coma
- Deafness
- Embolism/Thrombophlebitis
- Emphysema
- Hip/knee replacement
- Kidney failure
- Loss of speech
- Major or severe burns
- Major organ transplant
- Major trauma
- Multiple sclerosis
- Neuro-degenerative disease
- Paralysis
- Parkinson's disease
- Rheumatoid arthritis
- Stroke
- Sudden blindness due to illness

How It Works

WorldCare is a service that covers you and your immediate family members in the event you require a second opinion for a medical diagnosis or surgical opinion. WorldCare follows a simple 3-step process:

1. Call a WorldCare Member Care Representative to initiate a Second Opinion.
2. WorldCare works with your physician to gather medical records and determine the medical institution or institutions best suited to address your medical condition.
3. The designated physician team reviews your medical records and provides an independent WorldCare Second Opinion to you and your doctor.

Service Features

You and your eligible dependents are entitled to receive a WorldCare Second Opinion for acute, complicated and serious covered medical conditions. WorldCare's comprehensive, multi-disciplinary Second Opinion includes:

- A review of relevant medical records and supporting diagnostic information, and the interpretation of CT scan, MRI scan, X-ray, ultrasound, or other radiology or pathology studies by specialists at the WorldCare Consortium institutions, and the transmittal to of a written report which confirms a diagnosis and provides a suggested treatment plan.
- Educational and reference material relating to the diagnosis.
- Background information on the specialists and hospitals that provided the second opinion.

A WorldCare Second Opinion can typically be provided within an average of five (5) business days **AFTER** WorldCare has received and translated the complete medical record, and pathology, if any, has been reviewed.

If you decide to travel to the U.S. for care pertaining to the Second Opinion you will have access to WorldCare's Care Coordination services. These services include assistance with the following:

- Identifying and selecting a hospital or specialist for care in the U.S.
- Arranging appointments for care, including hospital admission and physician referrals (including, but not limited to appointments at Consortium hospitals).
- Identifying and recommending arrangements for any specialized transportation needs.
- Identifying any special requirements, such as cultural or language considerations.
- Facilitating discharge planning and return trip home.

Exclusions and Limitations

All medical records, diagnostic data, test results, images, studies, proposed treatment plans, and information on the condition for which the Second Opinion is requested must be provided to WorldCare within thirty (30) days of the receipt of the Patient Request & Consent Form, to be considered a single Second Opinion. If the information is submitted after 30 days from the initial Patient Request & Consent Form submission, and WorldCare has not yet initiated a Second Opinion from a Consortium Institution, WorldCare may require a new Patient Request & Consent Form.

A. You and each of your eligible dependents are entitled to two Second Opinions in each Policy Year, up to maximum of six Second Opinions during a lifetime. Extended Health Care must be in force at the time the service is requested.

B. Conditions resulting from the following are excluded from coverage:
   - Attempted suicide, self-inflicted injuries or injuries caused by a third person with the person's knowledge.
   - Alcohol or Drug Abuse.
   - Radioactive Contamination.
   - War or warlike operations (whether war is declared or not), riot, civil commotion, revolution, insurrections, conspiracy, or any events or causes which determine the proclamation or maintenance of martial law or state of siege.
   - Work related poisoning or poisonous gas inhalation.

C. Coverage shall automatically terminate when any of the following occur:
   - When the total number of Second Opinions received reaches 6 (six).
   - Upon expiration of the Extended Health Care coverage under the Sirius policy.
   - Upon the death of the member.

D. Member-Preferred Institutions. Unless otherwise requested by the member, WorldCare will select the medical institution from which to request the WorldCare Second Opinion. If the member requests a specific medical institution within the Consortium, WorldCare will make every effort to accommodate the request. However, while WorldCare will continue to strive for a five day turnaround, specific requests may delay the turnaround time.

Right of Refusal: WorldCare and the Consortium physicians make every effort to provide a Second Opinion based upon the information provided. Our Second Opinions are held to the highest standards of quality, and require the consulting physicians to adhere to strict guidelines. However, in certain cases, the medical information submitted may not be sufficient, or of adequate quality to render an opinion. In such cases, WorldCare will inform the member, within 24 hours of review of the medical information available, of the reasons for the inability to deliver a report and there will be an opportunity to deliver additional or alternative material to WorldCare. The consulting physician maintains the right to refuse to deliver a Second Opinion if the information is still insufficient.

To initiate your WorldCare consultation, contact WorldCare at 1-877-676-6439.
You may also learn more at www.worldcare.com