Contract Number: 103294, CI10217701, OE10217701
Effective: April 1, 2022
Issued: February 7, 2022

your group benefits

Ingram Micro Inc.

Full-time Associates

Sun Life Financial

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How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-800-361-6212.

For faster service, have your **group contract number** and **member ID** ready to enter into our automated telephone system.

Plan Member Services

Download the my Sun Life Mobile App!

- Free from the Apple App Store or Google Play, anytime
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

Access to mysunlife website

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

Prior Authorization Program

For the form:

- visit our website at www.mysunlife.ca/priorauthorization
- call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212

For the list of drugs:

- visit our website at www.mysunlife.ca/priorauthorization

Your Drug Card

Provided by your employer or online at www.mysunlife.ca.

Note: If you have refused Extended Health Care coverage under this plan, this drug card does not apply to you.

Your Travel Card

Provided by your employer or online at www.mysunlife.ca.

Note: If you have refused Extended Health Care coverage under this plan, this travel card does not apply to you.

Need to contact Allianz Global Assistance?

In the USA and Canada, call: 1-800-511-4610.

All other inquiries

Call 1-877-SUN-LIFE (1-877-786-5433).

Benefit Summary

The information contained in this summary applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Critical Illness Program and Voluntary Accidental Death & Dismemberment Insurance benefits described later in this booklet are not insured or administered by Sun Life.

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Waiting period	3 months of continuous employment Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care - Contract Number 103294

	Bronze	Silver	Gold
Benefit year	April 1 to March 31		
Deductible	None	None	None
Reimbursement level	For all eligible expenses, the reimbursement percentages are described below.	For all eligible expenses, the reimbursement percentages are described below.	For all eligible expenses, the reimbursement percentages are described below. However, for Prescription drugs, In-Province hospital and Medical services and equipment (excluding dental accident) combined, the reimbursement percentages described below apply to the first $1,000 of out of pocket expenses per person per benefit year. Thereafter, any eligible expenses in excess of $1,000 of out of pocket expenses per person per benefit year are paid at 100%.

	Bronze	Silver	Gold
Drug card plan	Included	Included	Included
Prescription drugs	70%	80%	90%
	Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation* We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist: • drugs that legally require a prescription • life-sustaining drugs that may not legally require a prescription • injectable drugs and vitamins • compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN • diabetic supplies • products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $500 per person • drugs for the treatment of infertility, up to a lifetime maximum of $3,000 per person • vaccines • intrauterine devices (IUDs) and diaphragms • colostomy supplies • varicose vein injections • drugs for the treatment of sexual dysfunction, up to a maximum of $750 per person per benefit year There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.		
Other health professionals allowed to prescribe drugs	We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.		
Dispensing fee	Eligible expenses for the dispensing fee are limited to $6 for each prescription or refill, and are covered at 100%	Eligible expenses for the dispensing fee are limited to $6 for each prescription or refill, and are covered at 100%	Eligible expenses for the dispensing fee are limited to $10 for each prescription or refill, and are covered at 100%
Drug substitution limit	We will not cover charges above the lowest priced equivalent drug unless we specifically approve them. To assess the medical necessity of a higher priced drug, Sun Life will require the covered person and the attending doctor to complete and submit an Exception Form.		
Québec drug insurance plan	Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements		
In-province hospital	70% of the difference between the cost of a ward and a semi-private room	80% of the difference between the cost of a ward and a semi-private room	90% of the difference between the cost of a ward and a private room

	Bronze	Silver	Gold
Convalescent hospital	70% of the difference between the cost of a ward and a semi-private room, up to $20 per day for a maximum of 180 days for treatment of an illness due to the same or related causes	80% of the difference between the cost of a ward and a semi-private room, up to $75 per day for a maximum of 60 days for treatment of an illness due to the same or related causes	90% of the difference between the cost of a ward and a semi-private room, up to $75 per day for a maximum of 60 days for treatment of an illness due to the same or related causes
Out-of-province emergency services	100% Emergency Travel Assistance included Maximum of 60 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Maximum of 60 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Maximum of 60 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services
Out-of-province referred services	100% Benefit year maximum of $100,000 per person for out-of-Canada services	100% Benefit year maximum of $100,000 per person for out-of-Canada services	100% Benefit year maximum of $100,000 per person for out-of-Canada services
Medical services and equipment	Not covered Hearing aids – Not covered Dental Accident – 100%	80% Hearing aids – 80% $300 per person over 5 benefit years. Repairs are included in this maximum Dental Accident – 100%	90% Hearing aids – 90% $500 per person over 5 benefit years. Repairs are included in this maximum Dental Accident – 100%
Paramedical services	Not covered	80%, up to a maximum of $300 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • massage therapists • physiotherapists • naturopaths • osteopaths or osteopathic practitioners • chiropractors. X-ray examinations have a separate maximum of 4 x-rays each benefit year and limited to $25 per x-ray • podiatrists or chiropodists	90%, up to a maximum of $500 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • massage therapists • physiotherapists • naturopaths • osteopaths or osteopathic practitioners • chiropractors. X-ray examinations have a separate maximum of 4 x-rays each benefit year and limited to $25 per x-ray • podiatrists or chiropodists

	Bronze	Silver	Gold
Other paramedical services	Not covered	80%, up to a maximum of $750 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • psychologists, social workers or psychotherapists	90%, up to a maximum of $1,500 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • psychologists, social workers or psychotherapists
	Not covered	80%, up to a maximum of $500 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • speech therapists	90%, up to a maximum of $1,000 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • speech therapists
Vision Care	Contact lenses, eyeglasses or laser eye correction surgery – 100% up to a maximum of $150 per person in any 24 month period Services of an ophthalmologist or licensed optometrist – 100% up to a maximum of one examination per person in any 12 month period for a person under age 18 or in any 24 month period for any other person Contact lenses for the treatment of specific medical conditions – 100% up to a maximum of $200 per person in any 24 month period	Contact lenses, eyeglasses or laser eye correction surgery – 100% up to a maximum of $350 per person in any 24 month period Services of an ophthalmologist or licensed optometrist – 100% up to a maximum of one examination per person in any 12 month period for a person under age 18 or in any 24 month period for any other person Contact lenses for the treatment of specific medical conditions – 100% up to a maximum of $200 per person in any 24 month period	Contact lenses, eyeglasses or laser eye correction surgery – 100% up to a maximum of $500 per person in any 24 month period Services of an ophthalmologist or licensed optometrist – 100% up to a maximum of one examination per person in any 12 month period for a person under age 18 or in any 24 month period for any other person Contact lenses for the treatment of specific medical conditions – 100% up to a maximum of $200 per person in any 24 month period
Lock-in period	There is a 2 year lock in period for vision care		
Changes in options	You can change your option during the annual enrolment period or within 31 days of a life event change. You can move up to any option but can only move down by one option at a time. Proof of good health is not required.		
Termination	When you retire or reach age 70, whichever is earlier		

Dental Care - Contract Number 103294

	Bronze	Silver	Gold
Benefit year	April 1 to March 31		
Deductible	None	None	None
Fee guide	The current fee guide for general practitioners in the province where the treatment is received		
Reimbursement level			
Preventive procedures	100%	100%	100%
Basic procedures	Scaling and root planing – 100% Other procedures – 80%	Scaling and root planing – 100% Other procedures – 80%	Scaling and root planing – 100% Other procedures – 80%
Major procedures	Not covered	50%	50%
Orthodontic procedures	Not covered	Not covered	50%, only for children under age 19
Maximum benefit			
Benefit year maximum	$1,500 per person	$2,000 per person	$2,000 per person A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime Orthodontic maximum	Not Applicable	Not Applicable	$2,000 per person
Lock-in period	None		
Changes in options	You can change your option during the annual enrolment period or within 31 days of a life event change. You can move up to any option but can only move down by one option at a time. Proof of good health is not required		
Termination	When you retire or reach age 70, whichever is earlier		

Health Spending Account - Contract Number 103294

Benefit year	April 1 to March 31
Credits	Remaining Flex credits at the beginning of each benefit year
Eligible expenses	Expenses that are considered eligible medical, hospital and dental expenses under the Income Tax Act (Canada) and are not paid, or not paid in full, under your group plan, your spouse's plan or any government-sponsored plan

Termination	When you retire or reach age 70, whichever is earlier

Short-Term Disability - Contract Number 103294

Maximum amount	66.67% of your weekly basic earnings up to a maximum of $2,500 The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Short-Term Disability* section of this booklet
Elimination period	Accident – none Illness – 7 days of uninterrupted total disability or the period up to the day you are hospitalized, whichever is shorter. To be considered hospitalized, you must have either: • been admitted in a hospital overnight as an in-patient • been admitted in a hospital as an outpatient and have undergone a surgical intervention • undergone a procedure under general or epidural anaesthesia in either a hospital, medical clinic or doctor's office
Maximum benefit period	17 weeks Benefits may also end on an earlier date as specified in the *Short-Term Disability* section of this booklet
Termination	When you retire or reach age 65, whichever is earlier
Tax status	Your employer has indicated that it is paying all or a portion of the premium for this disability plan. Therefore, the benefit payments are taxable income.

Long-Term Disability - Contract Number 103294

	Option 1	Option 2	Option 3
Maximum amount	50% of your monthly basic earnings up to a maximum of $16,000	66.67% of the first $2,250 of your monthly basic earnings, plus 50% of the balance of your monthly earnings, up to a maximum benefit of $16,000	66.67% of the first $2,250 of your monthly basic earnings, plus 50% of the balance of your monthly earnings, up to a maximum benefit of $16,000
	The maximum amount may be reduced by benefits and payments provided from other sources as described in *the Long-Term Disability* section of this booklet		

	Option 1	Option 2	Option 3
Cost of living adjustment	Not Applicable	Not Applicable	Your Long-Term Disability payment will be increased in January of each year to reflect the average increase, if any, in the Canadian Consumer Price Index over the 12 month period ending 3 months prior to the date of any adjustment. Any percentage increase to your benefit payment cannot exceed 3%. In the event of deflation, we will not decrease your benefit payment.
Proof of good health	Approval required for coverage in excess of $12,000, and any increase in that coverage of 25% or more or $500, whichever is greater		
Elimination period	17 weeks		
Maximum benefit period	The period ending on the last day of the month in which you reach age 65, or until the end of the maximum benefit period of 12 months if you have not ready received 12 months of Long-Term Disability payments when you reach age 65 Benefits may also end on an earlier date as specified in the *Long-Term Disability* section of this booklet		
Termination	The day you reach age 65 less the elimination period or the day you retire, whichever is earlier		
Tax status	Your employer has indicated that this disability plan is an employee-pay-all plan which means all required premium is paid by the employees covered under the plan. Therefore, the benefit payments are not taxable income.		

Life - Contract Number 103294

Employee Basic Life

Amount	2 times your annual basic earnings rounded to the next higher $1,000 Maximum – $1,000,000
Proof of good health	Approval required for coverage in excess of $875,000, and any increase in that coverage of 25% or more or $25,000, whichever is greater
Reduction	Coverage is reduced to 50% of the above amount when you reach age 65

	If you continue, or begin, to work after having reached age 65, we calculate the amount for which you would have been eligible if you had not already reached age 65, and it is that amount that will be used to determine if you have to submit proof of good health; then, we apply the above reduction clause to calculate the amount for which you are eligible.
Termination	When you retire or reach age 70, whichever is earlier

Employee Optional Life

Amount	You can choose 1, 3 or 5 times your annual basic earnings, rounded to the next higher $1,000
Overall maximum	$1,000,000 for basic and optional combined
Proof of good health	Approval required for coverage in excess of $875,000, and any increase in that coverage of 25% or more or $25,000, whichever is greater for basic and optional combined
Termination	When you retire or reach age 70, whichever is earlier

Spouse Optional Life

Amount	You can choose coverage of $10,000, $20,000, $50,000, $100,000 or $150,000
Proof of good health	Approval required for coverage in excess of $20,000, and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier

Child Optional Life

Amount	You can choose coverage of $5,000, 10,000 or $20,000 per child
Termination	When you retire or reach age 70, whichever is earlier

Making Claims

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator.

There are time limits for making claims. You can find more on these time limits in the following chart. **If you fail to meet these time limits, you may not be entitled to some or all benefit payments**.

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Ask your employer for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Extended Health Care coverage.
Emergency Travel Assistance	Contact Allianz Global Assistance to notify them that a medical emergency exists.	**Having expenses reimbursed:** To have services or supplies reimbursed that either you or another covered person have paid for, proof of the expenses must be provided to us within 30 days of the person's return to the province where the person lives. Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.

Type of claim	Starting the claims process	Limits and special instructions
Dental Care	Ask your employer for the form to complete, or get the form on our website. The dentist will have to complete a section of the form. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Dental Care coverage. If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information. For orthodontic procedures, a treatment plan will need to be submitted to us.
Health Spending Account	Ask your employer for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to 90 days after the earlier of the following dates: • the end of the benefit year during which the expense is incurred, or • the end of your Health Spending Account coverage.
Short-Term Disability	Ask your employer for the claim forms, and ensure that the following people complete them: • you, • your attending doctor, and • your employer.	Up to 30 days after your total disability begins. We will assess the claim and send you or your employer a letter that outlines our decision. From time to time, we can require that you provide us with proof of your continued total disability. We must be provided with this information within 90 days of the request.

Type of claim	Starting the claims process	Limits and special instructions
Long-Term Disability	Ask your employer for the claim forms and ensure that the following people complete them: • you, • your attending doctor, and • your employer. The submission of these forms is your proof of claim.	You should submit your proof of claim at least 8 weeks prior to the completion of your elimination period, but in no event later than 90 days after the end of your elimination period. If your Long-Term Disability coverage terminates, you must advise us of the claim within 30 days of the date the coverage terminates. We will assess the claim and send you or your employer a letter outlining our decision. From time to time, we can require that you provide us with proof of your continued total disability. We must be provided with this information within 90 days of the request.
Life coverage	Ask your employer to provide the claim forms.	**If the claim is a result of a death:** We must receive the claim form as soon as possible after the death occurred. **For coverage during total disability:** We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

General Information

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Critical Illness Program and Voluntary Accidental Death & Dismemberment Insurance benefits described later in this booklet are not insured or administered by Sun Life.

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Talk to your employer.

Your group benefits	The contract holder, Ingram Micro Inc., self-insures the Health Spending Account benefit. This means Ingram Micro Inc. has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.
Who is eligible to receive benefits?	To be eligible for group benefits, you must reside in Canada and meet all the following conditions: • you are a permanent employee working in Canada. • you are actively working for your employer at least 20 hours a week. • you have completed the waiting period indicated in the Benefit Summary. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent. You must apply for coverage for yourself in order for your dependents to be eligible.
Who qualifies as your dependent	Your dependent must be: • your spouse or your child, and • residing in Canada or the United States. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage. • under any other formal union recognized by law. • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship. You can only cover one spouse at a time. **Your children and your spouse's children** (other than foster children) are eligible dependents if they are under age 22 and do not have a spouse. A child who is a full-time student under age 26 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse.

	If a child becomes disabled before the maximum age and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**
How to enrol	*For you* – You must provide the proper enrolment information to Sun Life through your employer. *For a dependent* – You must ask for dependent coverage. As part of the enrolment process, for Extended Health Care, Vision Care, Dental Care and Long-Term Disability, you must elect one of the options of coverage described in *Benefit Summary*. If you do not make an election within 31 days of the date you become eligible for coverage, you will be covered for: • Extended Health Care – Silver option • Vision Care – None • Dental Care – Silver option • Long-Term Disability – Option 1 If you or your dependents already have similar Extended Health Care or Dental Care coverage under this or another plan – You may refuse this coverage under this plan. If the other coverage ends at a later date, you can enrol for coverage under this plan then. You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health. • Employee Basic Life • Employee Optional Life • Spouse Optional Life • Long-Term Disability
When coverage begins	Your coverage begins **on the later of** the following dates: • the date you become eligible for coverage. • the date Sun Life approves your proof of good health, if required. If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work. A dependent's coverage begins **on the later of** the following dates: • the date your coverage begins. • the date you first have a dependent. If you are not actively working on the date Optional Life coverage for your spouse or children would normally begin, then that coverage will not begin until you return to active work with your employer.
Changes affecting your coverage	You may change your election of coverage during the annual enrolment period, subject to any lock-in periods described in the Benefit Summary. You may also change your election of coverage within 31 days of a life event change.

	Changes elected during the annual enrolment period take effect **on the later of** the following dates: • the following April 1. • the date Sun Life approves any proof of good health that is required. Changes elected within 31 days of a life event change take effect **on the later of** the following dates: • the date of the life event change. • the date Sun Life approves any proof of good health that is required. If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health. If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
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: • change of dependents. • change of name. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-800-361-6212.
When coverage ends	As an employee, your coverage will end on the earlier of the following dates: • the date your employment ends or you retire. • the date you are no longer actively working. • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends. A dependent's coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage. The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

If you die while covered by this plan

Coverage for your dependents will continue, without anyone paying further premiums, until **the earlier of** the following dates:

- 24 months after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

For Extended Health Care, Vision Care and Dental Care, your dependents will continue to be covered for the option of coverage in effect on the date of your death.

When dependent coverage continues, it is subject to all other terms of the plan.

The continuation of coverage does not apply to Spouse and Child Optional Life.

Legal actions for insured benefits

Limitation period for Ontario:

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 *Limitations Act, 2002*.

Limitation period for any other province:

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 other applicable legislation of your province or territory.

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total eligible expenses.

When you have more than one plan, insurance industry standards determine which plan you should claim expenses from first.

Please send in claims for you and your spouse in the following order:

- First, send in the claim to the plan where the person is covered as an employee. If the person is an employee under two plans, send the claim to the different plans in the following order:
- to the plan where the person is covered as an active full-time employee.
- then, to the plan where they are covered as an active part-time employee.
- then, to the plan where they are covered as a retiree.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

- First send in the claim to the plan where the child is covered as an employee.
- Then, to the plan where they are covered under a student health or dental plan through their educational institution.
- Then, to the plan of whichever parent has the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.

When you send us a claim, you must tell us about all other equivalent coverage that you or your dependents have.

Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefits.

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits appear in the benefit sections.

Accident	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
Appropriate treatment	Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.
Annual enrolment period	The period designated by your employer immediately prior to April 1st of each year.
Basic earnings	Basic earnings are the salary you receive from your employer, including retroactive earnings, vacation and sick time, but excluding any bonus, overtime or incentive pay. If you are a commissioned salesperson, basic earnings are your average earnings over the past 2 years, including commissions. If employed less than 2 years, basic earnings are your average earnings since your date of hire, including commissions.
Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Illness	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Life event change	Life event changes include: • marriage or any other formal union recognized by law, or common-law, • birth or adoption of a child, • divorce or legal separation, • loss of spouse's benefit coverage • loss or gain of a dependent child because of age, or • death of a dependent.
Lock-in period	The minimum time that you must remain with your chosen option.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Extended Health Care

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

In this section, *you* means the employee and all dependents covered for Extended Health Care benefits.

Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required for treating an illness according to Canadian medical standards.

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

Reference to Doctor may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a doctor. For drugs, refer to *Other health professionals allowed to prescribe drugs* outlined in the Benefit Summary.

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.

Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.
What is not covered	We will not pay for the following, even when prescribed: • infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments. • the cost of giving injections, serums and vaccines. • treatments for weight loss, including drugs, proteins and food or dietary supplements. • hair growth stimulants. • drugs that are used for cosmetic purposes. • natural health products, whether or not they have a Natural Product Number (NPN). • drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
Drug evaluation	The following drugs will be evaluated and must be approved by us to be eligible for coverage: • drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017. • drugs covered under this plan and subject to a significant increase in cost. Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval. We will assess the eligibility of the drug based on factors such as: • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • availability of other drugs treating the same or similar condition(s). • plan sustainability.
Pharmaceutical services (rendered by pharmacists)	For employees residing in Québec, we will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.
Prior authorization program	The prior authorization (PA) program applies to a limited number of drugs, where you must get approval in advance for coverage under the program. In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form. You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as: • Health Canada Product Monograph. • recognized clinical guidelines. • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • your response to preferred drug therapy. If not, your claim will be declined. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.

Reference Drug Program	The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will: • group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*). • determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness. • limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*). • apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category*. For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as: • clinical support for switching to the *Reference Drug*. • expected duration of treatment. • provincial programs. Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*. When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

Hospital expenses in your province

Hospital	We will cover the cost of room and board in a hospital in the province where you live, as indicated in the Benefit Summary. A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.
Convalescent hospital	We will cover the cost of room and board in a convalescent hospital, as indicated in the Benefit Summary, if this care has been ordered by a doctor and as long as it is primarily for rehabilitation, and not for custodial care. A *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Expenses out of your province

Expenses out of your province	We will cover emergency services while you are outside the province where you live. We will also cover referred services. **For both emergency services and referred services, the reimbursement level is indicated in the Benefit Summary.** For both emergency services and referred services, we will cover the cost of: • a semi-private hospital room • other hospital services provided outside of Canada • out-patient services in a hospital • the services of a doctor
Emergency services	We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged. *Emergency services* mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established treatment program that existed before they left their home province. *Emergency* means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. **Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*) right away. Allianz Global Assistance must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them. **If Allianz Global Assistance does not hear from you first, before** you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency. In extreme circumstances where contact with Allianz Global Assistance cannot be made before services are provided, you must contact Allianz Global Assistance as soon as possible afterwards. An emergency ends when Allianz Global Assistance, based on available medical evidence, deems you medically stable to return to the province where you live.
Emergency services excluded from coverage	Any expenses related to the following emergency services are not covered: • services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services. • services relating to an illness or injury which caused the emergency, after such emergency ends.

	• continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Allianz Global Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return. • services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services. • where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.
Referred services	*Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services. All referred services must be obtained in Canada, if available, regardless of any waiting lists. However, if referred services are not available in Canada, they may be obtained outside of Canada.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private duty nurse	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties	$10,000 per person per benefit year
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	

Covered expenses	Details	Payment limits
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor • ultrasounds • medical imaging services, including MRIs and CT scans	For all medical imaging services combined, $1,000 per person per benefit year
Dental services following an accident	Dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered You must receive these services within 12 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the employee lives
Contact lenses or intraocular lenses	After cataract surgery	One lens per eye, per lifetime
Wigs	After chemotherapy	$300 per person per benefit year
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs	For wheelchairs, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses or crutches		
Splints or braces	Must be prescribed by a doctor	
Breast prostheses	Required as a result of surgery	One prosthesis per breast per benefit year

Covered expenses	Details	Payment limits
Surgical brassieres	Required as a result of surgery	2 brassieres per person per benefit year
Artificial limbs and eyes		
Stump socks		5 pairs per person per benefit year
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	4 pairs per person per benefit year
Custom-made orthotics for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	Combined maximum of $500 per person per benefit year
Hearing aids		Up to the reimbursement level indicated in the Benefit Summary
Oxygen		
Blood glucose monitors		One monitor per person over 4 benefit years
Continuous Glucose Monitor (CGM) receivers, transmitters or sensors	Only for persons diagnosed with Type 1 diabetes You must provide us with a doctor's note confirming the diagnosis	Combined maximum of $4,000 per person per benefit year
Insulin pumps	Must be prescribed by a doctor	
TENS machines	Must be prescribed by a doctor	$700 per person, per lifetime
Mechanical or hydraulic lifts	Must be prescribed by a doctor	One lift up to a maximum of $2,000 per person over 5 benefit years
Wheelchair ramps	Must be prescribed by a doctor	$2,000 per person, per lifetime
Elevated toilet seats, shower chairs, bathtub rails and standard commodes	Must be prescribed by a doctor	
Extremity pumps	Must be prescribed by a doctor	$1,500 per person, per lifetime

Covered expenses	Details	Payment limits
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary
Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us. *Qualified* paramedical practitioners must: • belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us, • be licensed or registered, as required by the applicable provincial regulatory body, • have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered, • maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association, • produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and • not engage in administrative practices unacceptable to us. This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.		
Vision care		
Contact lenses, eyeglasses or laser eye correction surgery and services of an ophthalmologist or licensed optometrist	An ophthalmologist or licensed optometrist must have prescribed contact lenses or eyeglasses You must have received the above from an ophthalmologist, licensed optometrist or optician We will only cover laser eye correction surgery that an ophthalmologist has performed	Up to the reimbursement level indicated in the Benefit Summary A separate maximum applies to contact lenses prescribed for the treatment of severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, if visual acuity in the better eye cannot be improved to at least 20/40 with eyeglasses We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

Payments after coverage ends

If you are totally disabled, as defined in the contract, when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and
- while this provision is in force.

If the Extended Health Care benefit ends, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

- the accident occurred while you were covered, and
- you have the procedure within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that we consider ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

We will not pay benefits when the claim is for an illness resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

Integrating this plan with government programs

This plan will integrate with benefits payable or available under the government-sponsored plan or program (the *government program*).

The covered expense under this plan is the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

Emergency Travel Assistance

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

In this section, *you* means the employee and all dependents covered for Emergency Travel Assistance benefits.

Emergency means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

The emergency services excluded from coverage, and all other conditions including maximums, limitations and exclusions that apply to your Extended Health Care coverage also apply to Medi-Passport.

Bring your Travel card with you! There you will find telephone numbers and the information you'll need to confirm your coverage and get help.

Getting help	**Contact us right away in an emergency!** You or someone with you must contact AZGA Service Canada Inc. (*Allianz Global Assistance*) right away.
	If Allianz Global Assistance does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Allianz Global Assistance cannot be made before services are provided, you must contact Allianz Global Assistance as soon as possible afterwards. Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card. Allianz Global Assistance may arrange for:
On the spot medical assistance	Allianz Global Assistance will provide referrals to physicians, pharmacists and medical facilities. As soon as Allianz Global Assistance is notified that you have a medical emergency, its staff, or a physician designated by Allianz Global Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Allianz Global Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service. Allianz Global Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel.

	Allianz Global Assistance will transmit an urgent message from you to your home, business or other location. Allianz Global Assistance will keep messages to be picked up in its offices for up to 15 days.
Transportation home or to a different medical facility	Allianz Global Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Allianz Global Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation. Sun Life or Allianz Global Assistance, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.
Meals and accommodations expenses	If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Allianz Global Assistance will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days. Allianz Global Assistance will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Allianz Global Assistance, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.
Travel expenses home if stranded	Allianz Global Assistance will arrange and, if necessary, advance funds for transportation to the province where you live: • for you if, due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated (sent home); or • **for a child** if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Allianz Global Assistance will also make arrangements and advance funds for a qualified person to go home with the child as their attendant. We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.
Travel expenses of family members	Allianz Global Assistance will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.

Returning you home (repatriation)	If you die while out of the province where you live, Allianz Global Assistance will pay up to $5,000 to do the following: • arrange for all necessary government authorizations. • arrange for the return of your remains in an approved container.
Returning your vehicle	Allianz Global Assistance will arrange and, if necessary, advance funds up to $500 to return a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from doing so.
Lost luggage or documents	If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Allianz Global Assistance will direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
Limits on advances	Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.
Reimbursement of expenses	If you obtain confirmation from Allianz Global Assistance that you are covered and a medical emergency exists, Sun Life will reimburse you for services and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Allianz Global Assistance. Allianz Global Assistance's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-800-361-6212. Allianz Global Assistance will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Allianz Global Assistance before your claim can be processed.
Coordination of coverage	If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.
Your responsibility for advances	You will have to reimburse Sun Life for any of the following amounts advanced by Allianz Global Assistance: • any amounts which are or will be reimbursed to you by your provincial medicare plan. • that portion of any amount which exceeds the maximum amount of your coverage under this plan. • amounts paid for services or supplies not covered by this plan. • amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you. Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received.

Limits on Emergency Travel Assistance coverage	There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before you leave on your trip. Allianz Global Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: • a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or an act of God. • the refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.
Liability of Sun Life or Allianz Global Assistance	Neither Sun Life nor Allianz Global Assistance will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Care

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

In this section, *you* means the employee and all dependents covered for Dental Care benefits.

Dental Care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, we will only cover **reasonable and customary charges**. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. When a fee guide is not published for a given year, the term fee guide may also mean an adjusted fee guide established by Sun Life.

Reasonable and customary charges mean*:*

- charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined by Sun Life.

We will base payments on the fee guide at the time the person receives the treatment.

To decide what part of a procedure we will pay for:

- we will first find out if you could have had alternate, or other, dental procedures.
- we confirm that these alternate procedures are part of usual and accepted dental work and produced a similar result to the procedure that the dentist performed.

We will only pay the reasonable cost of the least expensive alternate procedure.

For an implant related crown or prosthesis	We will pay the benefit that would have been payable under this plan for a tooth supported crown or a non-implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. **All other expenses related to implants, including surgery charges, are not covered.**
If you receive any temporary dental service	It will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the reasonable and customary charge for the final dental service.
Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. The benefit year is indicated in the Benefit Summary. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed, except for orthodontic procedures where an expense is incurred for each appointment. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary**.
Maximum benefit	Maximums are indicated in the Benefit Summary.
Getting an estimate before you have certain procedures	For any major treatment or any procedure that will cost more than $500, we suggest that you send us an estimate before the work is done. Here's what to expect: • you will send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. • both you and the dentist will have to complete parts of the claim form. • we will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Your dental services at a glance

Covered expenses	Details / Payment limits
Preventive dental procedures – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.	
Oral examinations	• 1 complete examination every 24 months. • 1 recall examination every 5 months, up to 2 examinations per benefit year. • emergency or specific examinations. • 2 periodontal examinations every 12 months.
X-rays	• 1 complete series of x-rays or 1 panorex every 24 months. • 1 set of bitewing x-rays every 5 months, up to 2 sets per benefit year. • x-rays to diagnose a symptom or examine progress of a certain course of treatment.
Other services	• required consultations between two dentists. • polishing (cleaning of teeth) and topical fluoride treatment once every 5 months, up to 2 per benefit year. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth and related anaesthesia. • providing space maintainers for missing primary teeth. • pit and fissure sealants, up to a maximum of one treatment per tooth every 5 years. • oral hygiene instruction once in a person's lifetime.
Basic dental procedures – Your dental benefits include the following procedures used to treat basic dental problems.	
Fillings	• amalgam (silver) and composite or acrylic (white), or equivalent.
Extraction of teeth	• removing teeth, except impacted teeth (*Preventive dental procedures*).

Covered expenses	Details / Payment limits
Basic restorations	• prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.
Endodontics	• root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.
Periodontics	• treating disease of the gum and other supporting tissue. • scaling and root planing, up to a combined maximum of 2 units of 15 minutes per benefit year for a child under age 13 or 10 units of 15 minutes per benefit year for any other person. • occlusal equilibration, up to a maximum of 4 units of 15 minutes per benefit year.
Oral surgery	• surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).
Repair of dentures	• repair of dentures – Not applicable to Bronze option.
Rebase	• rebase of an existing partial or complete denture, once every 36 months – Not applicable to Bronze option
Reline	• reline of an existing partial or complete denture, once every 36 months – Not applicable to Bronze option.
Resilient liners	• resilient liners, once every 36 months – Not applicable to Bronze option.
Denture adjustments	• denture adjustments, once every 12 months – Not applicable to Bronze option.
Major dental procedures – Your dental benefits include the following procedures used to treat major dental problems.	
Major restorations	• inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).
Repair of bridges	• repair of bridges.
Prosthodontics	Construction and insertion of bridges or standard dentures, limited to teeth extracted while a person is covered under this provision. We do not consider charges for a replacement bridge or replacement standard denture an eligible expense during the 5 year period after a previous bridge or standard denture is constructed or inserted**, unless either 1. or 2. below is true:** 1. it is needed to replace a bridge or standard denture which has caused temporomandibular joint (TMJ) disturbances and which cannot be economically modified to correct the condition. 2. it is needed to replace a transitional denture which was inserted shortly after teeth were extracted, where the dentist cannot economically get it to the final shape needed.
Orthodontic procedures – Your dental benefits include the following procedures used to treat misaligned or crooked teeth. **Only persons under the maximum age indicated in the Benefit Summary are covered for these procedures.**	

Covered expenses	Details / Payment limits
Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces	The following orthodontic procedures are covered: • interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*). • comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

Payments after coverage ends

If the Dental Care benefit ends, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

- the accident occurred while you were covered, and
- you have the procedure within 6 months after the date of the accident.

What is not covered

We will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

We will not pay for services or supplies that are not usually provided to treat a dental problem.

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- transplants and repositioning of the jaw.
- charges related to the temporomandibular joint (TMJ) treatment.
- charges related to implants, including surgery charges – Applicable to Bronze option.
- experimental treatments.

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.
- participation in a criminal offence.

Health Spending Account

Plan administrator

This benefit is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

Your Health Spending Account coverage provides reimbursement to you for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependent is your spouse, your children or any other person whom you may claim as dependents under the Income Tax Act (Canada). For example, this could include members of your extended family, such as your parents, grandparents or grandchildren. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care or Dental Care benefits.

The benefit year is indicated in the Benefit Summary.

How your Health Spending Account works	Your Health Spending Account works like an expense account. Your employer will allocate credits to your account in the manner described under *Credits* in the Benefit Summary. Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Health Spending Account.
Balance carry-forward	This plan is set up with a ***balance carry-forward*** feature. This means that you may be reimbursed for eligible expenses incurred in a benefit year using credits received during that benefit year, as well as any unused credits that have been carried forward from the previous benefit year. In other words, any credits remaining in your Health Spending Account at the end of one benefit year will be carried forward and may be used to reimburse you for eligible expenses incurred in the following benefit year. Credits that are carried forward from one benefit year to the next will be lost at the end of the second benefit year if you have not used them by then. Carried forward credits are always used before new credits are used. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
	There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not paid, or not paid in full, under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Eligible expenses	You can use your Health Spending Account to cover medical, hospital and dental expenses that are eligible under the Income Tax Act (Canada) and are not paid, or not paid in full, under your group plan, your spouse's plan or any government-sponsored plan. Eligible expenses include but are not limited to the items listed below: • portion of expenses not covered by a health or dental benefits plan such as deductibles, coinsurances or amounts over plan maximums. • premiums for health or dental benefits. • drugs or other preparations when prescribed by a qualified medical practitioner or dentist and dispensed by a pharmacist. • services performed by a qualified medical or dental practitioner. • payments to a hospital or another facility such as nursing home, special school, institution or other place for care and training of a mentally or physically impaired individual. • remuneration of a full-time attendant, or for the cost of full-time care in a nursing home of a mentally or physically impaired individual. Condition must be certified by a qualified medical practitioner. • emergency services or referred services outside the person’s province of residence. • eyeglasses, contact lenses or laser eye correction surgery when prescribed by a qualified medical practitioner. • medical devices, supplies or equipment when prescribed by a qualified medical practitioner. • diagnostic screening, laboratory or radiological procedures when prescribed by a qualified medical practitioner. • reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss. • transportation costs to transfer a patient and one additional person (if necessary) to receive medical services, if conditions for transportation expenses are satisfied and the distance travelled is at least 40 kilometres. • reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, if conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres. • costs of acquisition, care and maintenance (including food and veterinary care) of an animal specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs. • modifications to the principal home of the person who lacks normal physical development or who has severe and prolonged mobility impairment, to enable the person to gain access to a dwelling or to be functional within it. • reasonable expenses to locate a bone marrow or organ transplant donor, and reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant. *Qualified* means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Other coverage

If you or your eligible dependents have coverage under another plan, you should submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

Surviving dependent coverage

The Health Spending Account is set up under the employee's name, and there is no continuation of coverage for dependents after the employee's death. Only eligible expenses incurred before the employee's death can be reimbursed under the employee's Health Spending Account.

Short-Term Disability

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

Short-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you present proof of claim acceptable to Sun Life that confirms both of the following:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since it started.

For the purposes of your Short-Term Disability coverage, we will consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own occupation, in any workplace, including in a different department or location with your employer or with another employer. The availability of work with any employer does not affect the determination of total disability.

We will base your benefits on your coverage on the date you became totally disabled. We pay benefits at the end of each week for which you are entitled to payments.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

When disability payments begin	If you become totally disabled because of an accident or illness, you will be eligible for Short-Term Disability payments **on the later of the following:** • after you have been totally disabled for the number of days indicated in the Benefit Summary (elimination period), or • the first day you consult a doctor. If benefits are payable for part of any week, we will pay 1/7 of the weekly benefit for each day you are entitled to a payment.
What we will pay	Here is how we calculate your Short-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions. **Step 1: We take the maximum amount indicated in the Benefit Summary.** **Step 2:** (a) **During the entire period of total disability**, we subtract any benefits or payments provided: • under a motor vehicle insurance plan. • under a group plan which provides income replacement benefits as a result of an accident or an illness, including a multiple-employer group plan but excluding any benefits or payments provided under a Critical Illness plan or an association plan. • as part of a salary continuance received from your employer during your disability. • under the Québec Parental Insurance Plan. (b) **After the first 17 weeks of total disability**, when the maximum benefit period is more than 17 weeks, we also subtract any benefits or payments provided: • under any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan, excluding all benefits or payments on behalf of a dependent, for the same or a subsequent disability.

- under a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- under any coverage resulting from your membership in an association but excluding any benefits or payments provided under a Critical Illness plan.

The result from Step 2 is the amount you will normally receive.

However, if the amount calculated under Step 2, plus:

- **during the first 17 weeks of total disability** – the sources of benefits and payments listed in (a) above is more than 85% of your basic earnings when your disability began, we will reduce your Short-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.
- **after the first 17 weeks of total disability** – the sources of benefits and payments listed in (a) and (b) above is more than 85% of your basic earnings when your disability began, we will reduce your Short-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Important to remember:

- If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Short-Term Disability payments.
- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Short-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability reoccurs due to the same or related causes, we will consider it a continuation of your previous total disability as long as the disability reoccurs within 2 weeks of the end of your previous disability.

We will base these benefits on your coverage as it existed on the original date of total disability and will pay them for no longer than the rest of the maximum benefit period.

Rehabilitation program

Sun Life may require you to participate in a rehabilitation program that we have approved in writing.

This may include one or more of the following:

- consulting our rehabilitation specialist,
- part-time work,
- working in another occupation or vocational training to help you become capable of full-time employment.

During your rehabilitation program, you may receive Short-Term Disability payments plus income, benefits and payments from other sources.

However, if during any week the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began, your Short-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

For disability benefits paid or payable prior to the date of judgment or settlement, if you recover money, you must pay us 75% of your net recovery or the total disability benefits paid or payable to you under this plan, whichever is less. For disability benefits payable after a judgment or settlement, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits. Refer to your group contract for more information.

When payments end

Your Short-Term Disability payments end **on the earlier of** the following dates:

- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the date you retire on pension.
- the date you die.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- you are not participating in an approved rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks, unless Sun Life agrees in writing in advance to pay benefits during such period or unless the absence is for the purpose of obtaining medical treatment and would be permitted under the Employment Insurance regulations.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay if benefits are payable to you under any Workers' Compensation Act or similar legislation.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

Long-Term Disability

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

Long-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that confirms both of the following:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since it started.

For the purposes of your Long-Term Disability coverage:

- during the elimination period and the following 24 months (this period is known as the **own occupation period**), we consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own occupation, in any workplace, including in a different department or location with your employer or with another employer, and
- afterwards, we will consider you to be totally disabled while you are continuously unable due to an illness to perform any occupation, for any employer, for which you are or may become reasonably qualified by education, training or experience.

The availability of work with any employer does not affect the determination of total disability.

We pay these benefits at the end of each month. We base them on your coverage on the date you became totally disabled.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

When disability payments begin	Your Long-Term Disability payments begin **on the later of** the following dates: • after you have been totally disabled for the uninterrupted period indicated in the Benefit Summary. • after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan. This period, which must be completed before disability benefits become payable is called the **elimination period.**
What we will pay	Here is how we calculate your Long-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions. **Step 1: We take the maximum amount indicated in the Benefit Summary.** **Step 2: We subtract any benefits or payments provided under:** • any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan, excluding any benefits or payments on behalf of a dependent, for the same or a subsequent disability. • any Workers' Compensation Act or similar law for the same or a subsequent disability. • a motor vehicle insurance plan. • a group plan, including any coverage you have because you are a member of an association but excluding any benefits or payments provided under a Critical Illness plan.

- a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- the Québec Parental Insurance Plan.

The result from Step 2 is the amount you will normally receive.

Take the result you got in Step 2, add the above sources of benefits and payments plus the other sources of benefits and payments listed below and check the total you get. If it's more than 85% of your basic earnings when your disability began, we will reduce your Long-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Other sources of benefits and payments:
- any Workers' Compensation Act or similar law for another disability.
- any Criminal Injuries Compensation Act or similar law.

Important to remember:
- If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Long-Term Disability payments.
- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Long-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability reoccurs due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability.

We will base these benefits on your coverage as it existed on the original date you become totally disabled.

Rehabilitation / Partial disability program

Sun Life may require you to participate in a partial disability or rehabilitation program that we have approved in writing.

This may include one or more of the following:
- consulting our rehabilitation specialist,
- part-time work,
- working in another occupation or vocational training to help you become capable of full-time employment.

During your rehabilitation program, you may receive Long-Term Disability payments plus income, benefits and payments from other sources.

However, if during any month the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began, indexed for inflation, your Long-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

You should consider participating in a partial disability or rehabilitation program as soon as possible after becoming disabled. If you enter a partial disability or rehabilitation program during the elimination period, it will not be considered an interruption of the elimination period.

Your participation in a partial disability program will be limited to the own occupation period.

We will pay any expense associated with an approved rehabilitation program, other than normal employment expenses, as long as they are approved by us in writing in advance. The maximum amount during any one period of disability will be 3 times the amount of the monthly Long-Term Disability payment.

Expenses will not be covered if Sun Life notifies you in writing that the rehabilitation program is no longer approved or that it will no longer accept previously approved expenses.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

For disability benefits paid or payable prior to the date of judgment or settlement, if you recover money, you must pay us 75% of your net recovery or the total disability benefits paid or payable to you under this plan, whichever is less. For disability benefits payable after a judgment or settlement, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits. Refer to your group contract for more information.

What you are responsible to do

During your total disability, you must make reasonable efforts to do all of the following. If you do not, Sun Life may hold back or discontinue benefits.

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your own occupation during the first 24 months that benefits are payable.
- receive training to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to get work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

When payments end

Your Long-Term Disability payments end **on the earlier of** the following dates:

- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off.
- you are absent from Canada longer than 4 months due to any reason.
- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if you become totally disabled within 12 months after your coverage begins and your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if you have been covered for Long-Term Disability with your employer for at least 13 weeks during which:

- you have been actively working continuously (up to 3 days of absence does not count), and
- you have not been treated for the condition by a doctor or any medical personnel under the direction of a doctor.

If your coverage ends but you are covered again under this plan, we will use the latest date your coverage began when applying the above limitation.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

Waiver of premium

Long-Term Disability premiums will be waived while you are receiving Long-Term Disability benefits.

Life Coverage

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Life coverage provides a benefit if one of your dependents dies while covered.

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Who we will pay	If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. If a dependent dies, we will pay you the benefit for that dependent. For your spouse's optional coverage, we will pay the full amount of the benefit to the last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to you. **Fact** If you designated a beneficiary under a previous group plan of the employer, we will apply and carry it forward to your coverage under this plan until you change it. There are different rules for designating a minor beneficiary, please refer to your contract for specific information.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions.
Coverage during total disability	Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 65, whichever is earlier, as long as you are totally disabled. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations. There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact your employer for details.

Converting Life coverage

If your Life coverage or your spouse’s Life coverage ends or reduces for any reason other than your request, you or your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends because your Life coverage has ended, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days that the Life coverage reduces or ends.

Important
There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.

Critical Illness Program

Insurer

This benefit is insured by Chubb Life Insurance Company of Canada.

Eligibility

You will be eligible for coverage if you are an active, permanent, full-time employee of the Policyholder, under age 70.

Coverage can also be purchased by your spouse (legally married or a person who co-habits with you and has been represented as your domestic partner for a period of 1 year or longer in the community in which you reside and continues to be so represented) under age 70 or unmarried dependent children, including step, foster or legally adopted children who are under age 22, or under age 26, if the child is a full-time student and dependent on you or your spouse for financial support, or over age 21 if the child is dependent by reason of mental or physical infirmity and incapable of self-sustaining employment and dependent upon you or your spouse for financial support.

Insured Conditions

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Cancer Recurrence
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Independence
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

Additional Benefits

- Ductal Carcinoma in situ (DCIS) Benefit
- Early Stage Prostate Cancer (T1a or T1b) Treatment
- Hip or Knee Replacement Surgery (applicable to Mandatory Coverage Only)
- Second Event Benefit

Benefits & Coverage

Mandatory Coverage

Option 1: You are covered for a flat amount of $5,000.

Option 2: You are covered for a flat amount of $5,000

Option 3: You are covered for a flat amount of $5,000

Option 4: You are covered for a flat amount of $5,000

NOTE: Mandatory coverage benefit amount reduces by 50% upon your attainment of age 65.

Optional Coverage *(WITH NO MEDICAL EVIDENCE)*

Employee:

Option 1: No optional coverage

Option 2: Flat $10,000

Option 3: Flat $25,000

Option 4: Flat $50,000

Spouse: Choice of flat amount of $5,000, $10,000, $25,000 or $50,000

NOTE: All Mandatory and Optional coverages terminate upon your attainment of age 70.

A pre-existing condition limitation provision is applied.

What Is a Pre-Existing Condition Limitation?

This means that we won't pay for a critical condition diagnosed in the first 2 years of coverage, if that diagnosis was directly or indirectly caused by an injury or sickness you've received treatment, advice or a diagnosis on, in the 2 years just prior to your effective date of coverage.

Benefit Payment

If an Insured is diagnosed with or meets the definition of an Insured Condition or a Partial Payment Benefit condition, after the effective date or latest reinstatement date of coverage, and survives a period of 30 days following the date of diagnosis, or such longer period of time set out in the description of the insured condition or Partial Payment Benefit condition, the insurer will pay the applicable benefit.

Partial Benefits

Subject to the terms, conditions and other provisions of the policy, the insurer will pay the Partial Payment Benefit as set out below.

Please note that Partial Payment Benefits are not deemed to be Insured Conditions, nor do they fall under the category of Insured Conditions for the purposes of the Second Event Benefit.

Payment of a Partial Payment Benefit does not reduce eligible payment of a principal sum payment. Each Partial Payment Benefit is payable only once.

Ductal Carcinoma In Situ (DCIS)

"DCIS" means the diagnosis by a Physician, of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A Physician certified as an oncologist must confirm the diagnosis in writing.

The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the insured is diagnosed with DCIS and survives 30 days thereafter.

Early Stage Prostate Cancer Treatment

"Early Stage Prostate Cancer (T1a or T1b Treatment" means the diagnosis by a Physician certified as an oncologist of Early Stage Prostate Cancer with one of the following recommended treatments: Prostate Surgery, Radiation Therapy, Chemotherapy, or Hormone Therapy

The insurer will pay 20% of the Principal Sum up to a maximum of $20,000 if the Insured undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and the Insured survives 30 days thereafter.

No Partial Payment Benefit will be payable unless the Physician has recommended at least one of the above treatments.

Hip or Knee Replacement Surgery (only applicable to Mandatory Coverage)

The insurer will pay 10% of the Principal Sum up to a maximum of $10,000 if the insured has undergone surgery to

replace either the hip or the entire knee through the procedures set out below:

- Hip replacement qualifies if the femoral stem is replaced. This procedure is performed in both total arthroplasty and hemiarthroplasty (both monopolar and biopolar)
- Knee replacement qualifies if all three compartments of the knee (medial, lateral and patellofemoral compartments) are replaced. This procedure is also known as total knee replacement.

Hip replacement or knee replacement surgeries must be performed by a Specialist.

Second Event Benefit

If an Insured Person is diagnosed with either of the following Category of Conditions:

a. Cancer, or
b. Cardiovascular Condition (defined as Heart Attack, Stroke, Coronary Artery Bypass, undergoes Aorta Surgery or Heart Valve Replacement)

for which the Principal Sum has been paid and an Insured is thereafter considered (by the treating physician) fully recovered and not actively receiving treatment and has returned to work for a period of at least 90 days and is then diagnosed with another Insured Condition, the Second Event benefit payable will be equal to the Principal Sum.

The Second Event Benefit is subject to the Insured surviving 30 days after the diagnosis of such Insured Condition. An insured spouse is considered eligible for a Second Event 90 days after the required treatment has finished and they have survived 30 days after the diagnosis of such Insured Condition, except as provided for under Cancer Recurrence.

In order to be considered an eligible Second Event condition the first event and the second event cannot fall into the same Category of Conditions, except as provided for under Cancer Recurrence.

The Second Event Benefit is payable only once. Payment of the Second Event Benefit will represent full and final discharge of all claims under the Second Event Benefit. Following Payment of the Second Event Benefit, coverage under the policy will terminate.

Definitions of Insured Conditions

Alzheimer's Disease: means the diagnosis of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that the Insured Person exhibits the loss of intellectual capacity resulting in impairment of their memory and judgment, which results in a significant reduction in their mental and social functioning, such that they require permanent daily personal supervision for the activities of daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this insured condition definition. A physician who is certified as either a neurologist or a psychiatrist must confirm diagnosis in writing.

Aorta Surgery: means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a physician certified as a cardiovascular surgeon.
Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

Benign Brain Tumour: means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.
Blindness: means the total and irrecoverable loss of sight in both eyes due to injury or sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A physician certified in ophthalmology, must clinically confirm the diagnosis in writing.

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ

- Kaposi's Sarcoma (or other AIDS related cancers) and cancer in the presence of human immunodeficiency virus (HIV).
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth.
- Prostate cancer diagnosed as T1 N0M0 or equivalent staging.
- A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage, except as provided for under Cancer Recurrence.

A physician certified as an oncologist must confirm diagnosis in writing.

Cancer Recurrence means, if the insured person has already been diagnosed with Cancer and, while insured, a new diagnosis of Cancer is made, a benefit will
be paid, subject to all the policy terms and provisions, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No Treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

Coma: means you have been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A physician who is certified as a neurologist must confirm diagnosis in writing.

Coronary Artery Bypass Surgery: means surgery performed by a physician who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered Critical Illness.

Deafness: means the diagnosis of permanent loss of hearing in both of your ears, with an auditory threshold of more than 90 decibels in each ear. A physician, who is certified as an otolaryngologist must confirm diagnosis in writing.
Dismemberment: means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Heart Attack: means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a. heart attack symptoms; or
b. new electrocardiogram (ECG) changes consistent with a heart attack; or
c. development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

a. elevated biochemical cardiac markers with a:
    i. Troponin Level of less than 1
    ii. CK-Mb Level of less than 4, or
b. ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement: means undergoing surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist. **Exclusion:** No benefit will be payable under this condition for heart valve repair.

Loss of Speech: means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Loss of Independence: means the definitive diagnosis by a physician of either:

- Being totally and permanently unable to perform, by oneself, at least 2 of the 6 activities of daily living or,
- Cognitive impairment.

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of Independence must persist for a continuous period of 90 days from the date of the diagnosis with no reasonable chance of recovery as diagnosed by a physician.

Major Organ Failure: means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded) both lungs, both kidneys or bone marrow, in which the affected organ is unresponsive to any treatment and for which the Insured Person medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

Major Organ Transplant: means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease: means a definite diagnosis of one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal muscular atrophy
- Progressive bulbar palsy
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: means the unequivocal written diagnosis by a physician who is certified as a neurologist confirming at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Occupational HIV Infection: means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Person's effective date of coverage.

Payment under this condition requires satisfaction of all of the following:

a. The accidental injury must be reported to the insurer within 14 days of the accidental injury;
b. A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
c. A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d. All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
e. The accidental injury must be reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.
f. The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusions: No benefit will be payable under this condition if:

- The Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
- A licensed cure for HIV infection is available prior to the accidental injury; or,

- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to injury or sickness, provided such loss of function continually lasts for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent. A physician certified as a neurologist must confirm diagnosis in writing.

Parkinson's Disease: means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform 3 of the 6 activities of daily living without assistance. Diagnosis should show signs of progressive impairment and must be confirmed in writing by a physician who is certified as a neurologist.

Severe Burns: means the Insured Person has third degree burns covering at least 20% of the surface area of their body. A physician who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.

Stroke: means that the Insured Person has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the stroke, confirmed in writing by a physician who is certified as a neurologist.

Continuance of Coverage

If you are (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of 12 months following the beginning of any such event subject to continued payment of premium.

Waiver of Premium

If you (employee) are totally disabled while the plan is in force and you provide satisfactory evidence of total disability to the insurer on an annual basis, we will then waive the payment of premium. Subject to all the terms and conditions of the policy, waiver of any premium will continue with respect to your insurance and your dependents, until you attain age 65. If you cease to be totally disabled and you return to active employment with the policyholder, and are a member of an eligible class, the insurance may be continued upon resumption of premium payments.

Conversion

On the date of termination of employment or during the 31 day period following termination of employment, an Insured may convert his or her coverage under this policy to an individual insurance policy of the insurer. The individual policy will be effective either as of the date that the insurer receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as an Insured would ordinarily pay when applying for an individual policy at that time. The amount of Critical Illness insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of $25,000. The individual policy will cover the same conditions as those available under the group policy currently in force.

Limitations and Exclusions

The plan does not provide benefits for any of the specified coverages caused directly or indirectly by or resulting from intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; declared or undeclared war or any act thereof; injury or sickness, other than one of the specified insured conditions, even though such injury or sickness may have been complicated by one of the specified coverages; a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex; the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel; the commission or attempted commission by the Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed; misuse of medication or the abuse of drugs or intoxicants; or a pre-existing medical condition except where coverage has been in effect for a period of 24 months following your or your covered dependent's effective date of coverage.

90 Day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion

The insurer will not pay the Critical Illness Benefit for a diagnosis of DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment, and Cancer 90 days from the effective date, or latest reinstatement date of coverage.
In the event of a diagnosis within this 90 day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer exclusion period, coverage under this policy for the Insured will remain in force but DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer will be a Pre-Existing Condition and the Critical Illness Benefit will not be payable. This 90 day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion does not apply to a diagnosis of another Insured Condition or a subsequent diagnosis of an unrelated Cancer.

General Provisions

Beneficiary

You or your covered spouse have the right to name a beneficiary when applying for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under this policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured employee.

All other indemnities of the policy will be payable to the insured employee.
An insured person can change his beneficiary at any time, where permitted by law. The insurer assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

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, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.
The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to
obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

How to Claim

You may obtain the required forms from your Plan Administrator.

Notice of claim must be given to the insurer within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to the insurer within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will the insurer accept notice of claim beyond one year.

Voluntary Accidental Death and Dismemberment Insurance

Insurer

This benefit is insured by Chubb Life Insurance Company of Canada.

Coverage

The plan offers you full 24-hour protection against accidents, on or off the job, on business - on vacation - at home, regardless of your health history.

Eligibility

You will be eligible for insurance if you are an active, full-time associate of the policyholder under age 70.

Under the Family Plan, you insure your family members as follows: Your spouse, (legally married or domestic partner) under age 70 and your unmarried, dependent children, including natural, legitimate, illegitimate, adopted, step child or common law child, to age 22, or to age 25, if the child is a full-time student and dependent on you or your spouse for financial support, or over age 21 if the child is dependent by reason of mental or physical infirmity and incapable of self-sustaining employment and dependent upon you or your spouse for financial support.

Schedule of Losses

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life Insurance will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	66 2/3%
Loss of Entire Sight of One Eye	66 2/3%
Loss of Use of One Hand	66 2/3%
Loss of Speech or Hearing in Both Ears	66 2/3%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	25%
Loss of All Toes of Same Foot	12 1/2%

"Loss" shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to "Loss of Thumb and Index finger of Same Hand" or "Loss of Four Fingers of Same Hand", the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If you suffer complete severance of a hand, foot, arm or leg as described above, then Chubb Life Insurance will pay the amount specified above even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand or leg provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life Insurance to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Quadriplegia, Paraplegia, Hemiplegia losses are subject to an all policies combined maximum benefit amount of $1,500,000.

Rehabilitation Benefit

When injuries result in a payment being made by Chubb Life Insurance under any benefit excluding the Loss of Life Benefit, Chubb Life Insurance will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

a. such training is required because of such injuries and in order for the Insured employee to become qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling or clothing expenses.

Repatriation Benefit

When injuries covered by this plan result in a loss of life of an insured person outside 150 km from their city of permanent residence or outside of Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life Insurance will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Family Transportation Benefit

When injuries result in an insured person being confined as an in-patient in a hospital outside 150 km their city of permanent residence or outside of Canada, and requires personal attendance of a member of their immediate family as recommended by the attending physician, in writing, Chubb Life Insurance will pay for the expense incurred by the member of the family for the transportation by the most direct route by a licensed common carrier to the confined insured person , but not to exceed an amount of $15,000.

"Member of the immediate family" means the spouse, legal or common-law, parents, grandparents, children over age 18, brother or sister of the insured person.

When injuries to you result in a payment being made by Chubb Life Insurance under the Loss of Life Benefit, Chubb Life Insurance will pay in addition, the expenses actually incurred, within 365 days from the date of the accident, by your spouse for a formal occupation training program for the purpose of specifically qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an insured person sustains an injury which results in a payment being made under this plan, excluding

the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life Insurance will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

a. the one-time cost of alterations to the insured person's principal residence to make it wheelchair accessible and habitable; and
b. the one-time cost of modifications necessary to a motor vehicle utilized by the insured person to make the vehicle accessible or operable for the insured person.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum amount payable under both items 1 and 2 shall be the greater of $15,000 or 10% of your benefit amount to a maximum of $50,000.

Day Care Benefit

If you (the employee) suffer a loss of life in a covered accident while this policy is in force, Chubb Life Insurance will pay, in addition to all other benefits payable under the policy, a "Day Care Benefit" equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for four (4) consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

"Dependent Child" means either a legitimate or illegitimate child, adopted child, step-child or any child who is in a parent-child relationship with you and twelve years of age and under and dependent upon you for maintenance and support.

Continuance of Coverage

If you (the employee) are (1) laid off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums.

If you (the employee) assume other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Seat Belt Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, your benefit amount 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. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile. **"Seat Belt"** means those belts that form a restraint system.

Special Education Benefit

If you (the employee) suffer a loss of life in a covered accident under this policy , Chubb Life Insurance will pay, in addition to all other benefits payable under this policy, a "Special Education Benefit" equal to 5% of your benefit amount, (subject to a maximum of $5,000 per year), on behalf of your dependent child who, on the date of the accident, is enrolled as a full-time student in any post – secondary institution or was at the 12th grade level and subsequently enrolls as a full-time student in a post-secondary institution within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of four (4) consecutive annual payments but only if your dependent child continues his/her education as a full-time student in an institution of higher learning.

Conversion Privilege

On the date of termination of employment or during the 31 day period following termination of employment, you may convert your insurance to an individual insurance policy of Chubb Life Insurance. The individual policy will be effective either as of the date that the application is received by Chubb Life Insurance or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time. The amount of insurance benefit converted will not exceed that amount of issued during employment, up to a combined policy maximum of $200,000.

Waiver of Premium

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to Chubb Life Insurance on an annual basis, payment of premium will be waived until the earlier of the following occurs:

a. you return to active employment with your employer;
b. you attain age 65;
c. the master policy underwritten by Chubb Life Insurance is terminated.

Once you return to active employment with your employer, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if you are unable to engage in any business or occupation and perform in any work for compensation or profit and your disability has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

In-Hospital Confinement Monthly Income

In the event you sustain an injury which results in a payment being made under the Schedule of Losses of this policy, excluding the Loss of Life Benefit and the Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself, Chubb Life Insurance will pay for each full month, one percent (1%) of the Insured Person's Principal Sum, subject to a maximum benefit of $2,500, or one-thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Bereavement Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, Chubb Life Insurance will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured Person for up to six (6) sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $1,000.

"Professional Counsellor" means the treatment or counselling by a therapist or counsellor who is licensed, registered or certified to provide such treatment.

Identification Benefit

In the event accidental Loss of Life is sustained by the Insured Person not less than 150 km from the Insured Person's normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, Chubb Life Insurance will reimburse the reasonable expenses actually incurred by such member for:

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of three (3) days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described herein shall be covered to the extent of the benefits afforded you.

If an Insured Person's body has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which he/she was riding at the time of the accident it shall be presumed, subject to all other conditions of the policy, that he/she suffered a loss of life resulting from bodily injuries sustained in an accident covered under this plan.

Cosmetic Disfigurement Benefit

If, an Insured Person suffers a third degree burn in a non-occupational accident, Chubb Life Insurance will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table:

Body Part	(A) Area Classification	(B) Maximum allowable % for Area Burned	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	11	9%	99%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The maximum percent of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable percent for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Plan Descriptions
Core Plan: Full-time Associates

Option 1: Two (2) times annual earnings to a maximum of $1,500,000

NOTE: Core Plan benefit amount reduces by 50% upon your attainment of age 65.

Optional Plan: Full-time Associates, Spouses and Dependent Children

Option 2: Additional one (1) times annual earnings to an overall maximum of $1,500,000 in conjunction with the Core Plan
Option 3: Additional three (3) times annual earnings to an overall maximum of $1,500,000 in conjunction with the Core Plan
Option 4: Additional five (5) times annual earnings to an overall maximum of $1,500,000 in conjunction with the Core Plan

*The term "annual earnings" as used herein shall mean an Insured Person's basic annual salary excluding overtime, bonus or commission.

NOTE: Core Plan and Optional Plan benefit amounts terminate upon your attainment of age 70.

Family Plan:

a. Spouse & Eligible Dependent Children
   Spouse.....50% of Employee's Amount
   Each Child .....15% of Employee's Amount
b. Spouse & NO Eligible Dependent Children:
   Spouse.....60% of Employee's Amount
c. NO Spouse but Eligible Dependent Children:
   Each Child .....20% of Employee's Amount

Overall Maximums: Spouse: $350,000
Each Child: $ 50,000

NOTE: If you are covered under the plan as an employee you cannot also be covered as a spouse or dependent child of another employee. In addition, only one spouse can elect coverage for dependent children.

Effective Date and Period of Coverage

Coverage becomes effective on the first day of the month following the receipt of your application by the plan administrator. As long as your premium is paid, you will be protected until: (1) you become 70 years of age, or (2) you cease to be an eligible employee or (3) Chubb Life Insurance declines to renew the insurance for all those who enroll under the plan.

Exclusions

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. war or any act of war;
3. flying in an aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. full-time, active duty in the armed forces of any country or international authority;
5. flying as a pilot or crew member in any aircraft or device for aerial navigation.

General Provisions

Beneficiary

An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.
An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: 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. For residents of Manitoba: 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. For residents of Ontario: 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 Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

How to Claim

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life Insurance within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life Insurance within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not
reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life Insurance accept notice of claim beyond one (1) year.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than one in six Canadians, in over 12,000 corporate, association, affinity and creditor groups across Canada.

Our Core values – integrity, service excellence, customer focus and building value – are at the heart of who we are and how we do business.

Sun Life Financial and its partners have operations in 22 key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
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