your group benefits

Contract Number: 103441 and 153441
Effective: February 1, 2019
Issued: September 5, 2019

Mitel Networks Corporation

All Participants

Mitel

Sun Life Financial

Table of Contents

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 1-866-896-6976.

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 1-866-896-6976

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

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	The period ending on the last day of the month in which your employment began. However, if your employment began on the first day of the month, there is no waiting period. 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 153441

	Core	Option A	Option B	Option C
Benefit year	February 1, 2019 to December 31, 2019, and then from January 1 to December 31			
Deductible	None	None	None	None
Reimbursement level				
Drug card plan	Not Included	Included	Included	Included
Prescription drugs	Not covered	50% for drugs and supplies listed in the Provincial drug benefit plan	80% for drugs and supplies listed in the Provincial drug benefit plan and prior authorization drugs and 50% for all other eligible expenses	100% for drugs and supplies listed in the Provincial drug benefit plan and prior authorization drugs and 75% for all other eligible expenses
	For employees residing in Québec, the reimbursement percentage is increased to 100% for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached. However, if the drug submitted for reimbursement has a lower priced equivalent drug, only the cost of the lowest priced equivalent drug will be considered at 100%, unless Sun Life specifically approved the cost of the higher priced drug.			

Option A	We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist: • selected drugs with a Drug Identification Number (DIN) that are therapeutically useful and cost effective, listed in the Provincial drug benefit plan and approved under *Drug evaluation* • selected supplies that are therapeutically useful and cost effective, and listed in the Provincial drug benefit plan • selected natural health products with a Natural Product Number (NPN), where provided in the provincial drug benefit plan • compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN • colostomy supplies • drugs for the treatment of infertility, up to a lifetime maximum of $15,000 per person			
Option B and C	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 • drugs for the treatment of infertility, up to a lifetime maximum of $15,000 per person • colostomy supplies • varicose vein injections 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.			
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.			
	For employees residing in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless we specifically approved the charges for the higher priced drug.			
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	Not covered	50% of the difference between the cost of a ward and a private room	80% of the difference between the cost of a ward and a private room	100% of the difference between the cost of a ward and a private room

Convalescent hospital	Not covered	50% 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 all periods of 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 $20 per day for a maximum of 180 days for all periods of treatment of an illness due to the same or related causes	100% 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 all periods of treatment of an illness due to the same or related causes
Out-of-province emergency services	100% Emergency Travel Assistance included Time limit – 60 days after the date the person leaves the province where the person lives Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Time limit – 60 days after the date the person leaves the province where the person lives Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Time limit – 60 days after the date the person leaves the province where the person lives Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Time limit – 60 days after the date the person leaves the province where the person lives Lifetime maximum of $3,000,000 per person for out-of-Canada services
Out-of-province referred services	80%	80%	80%	80%
Medical services and equipment	Not covered	50%	80%	100%
Paramedical services	Not covered	50% up to a maximum of $250 per person per benefit year per specialty for the qualified paramedical practitioners listed below:	80% up to a maximum of $400 per person per benefit year per specialty for the qualified paramedical practitioners listed below:	100% up to a maximum of $500 per person per benefit year per specialty for the qualified paramedical practitioners listed below:
	• psychologists or social workers • massage therapists • physiotherapists or athletic therapists • naturopaths • acupuncturists • dieticians • osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year • podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year • chiropractors, including a maximum of one x-ray examination each benefit year			

Other Paramedical services	Not covered	50% for qualified speech therapists	80% for qualified speech therapists	100% for qualified speech therapists
Visual training	Not covered	Not covered	50% for visual training up to a maximum of $400 per person per benefit year	50% for visual training up to a maximum of $500 per person per benefit year
Vision Care	Not covered	Not covered	Contact lenses, eyeglasses, laser eye correction surgery or services of an ophthalmologist or licensed optometrist (eye examinations) – 100% up to a maximum of $250 in any 12 month period for a person under age 21 or in any 24 month period for any other person Contact lenses for the treatment of specific medical conditions – 100%, up to a lifetime maximum of $200 per person	Contact lenses, eyeglasses, laser eye correction surgery or services of an ophthalmologist or licensed optometrist (eye examinations) – 100% up to a maximum of $400 in any 12 month period for a person under age 21 or in any 24 month period for any other person Contact lenses for the treatment of specific medical conditions – 100%, up to a lifetime maximum of $200
Lock-in period	None	None	None	2 years
Change in options	Subject to the *lock-in period* indicated above, you can change your option during the *enrolment period* or within 31 days of a *life event change*. Proof of good health is required when the change is not requested during the enrolment period or within 31 days of a life event change. You can only move up or down by one option at a time.			
Best Doctors	Included			
Termination	When you retire			

Dental Care - Contract Number 153441

	Core	Option A	Option B	Option C
Benefit year	February 1, 2019 to December 31, 2019, and then from January 1 to December 31			
Deductible	None	None	None	None

Fee guide	Not applicable	The current fee guide for general practitioners, minus one year, in the province where the employee lives, regardless of where the treatment is received	The current fee guide for general practitioners, minus one year, in the province where the employee lives, regardless of where the treatment is received	The current fee guide for general practitioners in the province where the employee lives, regardless of where the treatment is received
Reimbursement level				
Preventive procedures	Not covered	80%	90%	100%
Basic procedures	Not covered	80%	90%	100%
Major procedures	Not covered	Not covered	60%	100%
Orthodontic procedures	Not covered	Not covered	50%	50%
Maximum benefit				
Benefit year maximum	Not applicable	$1,000 per person	$2,000 per person A separate lifetime maximum (below) applies to Orthodontic expenses	$2,500 per person A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime maximum	Not applicable	Not applicable	Orthodontic procedures – $2,000 per person	Orthodontic procedures – $3,500 per person
Late Applicant	Not applicable	$100 per person during the first 12 months for all expenses combined	$300 per person during the first 36 months for Orthodontic procedures and $100 per person during the first 12 months for all other expenses combined	$300 per person during the first 36 months for Orthodontic procedures and $100 per person during the first 12 months for all other expenses combined
Lock-in period	None	None	None	2 years
Change in options	Subject to the *lock-in period* indicated above, you can change your option during the *enrolment period* or within 31 days of a *life event change*. Late applicant maximum applies when the change is not requested during the enrolment period or within 31 days of a life event change. You can only move up or down by one option at a time.			
Termination	When you retire			

Health Spending Account - Contract Number 153441

Benefit year	February 1, 2019 to December 31, 2019, and then from January 1 to December 31
Credits	Remaining Flex credits at the beginning of each benefit year
Prorating	If your coverage starts after the benefit year begins, your credits are adjusted by the employer for that benefit year. If you need additional information, please contact your employer.
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

Long-Term Disability - Contract Number 103441

	Core	Option A	Option B
Maximum amount	60% of monthly basic earnings up to a maximum of $10,000	75% of monthly basic earnings up to a maximum of $10,000	60% of monthly basic earnings up to a maximum of $10,000
	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		
Cost of living adjustment	A cost of living adjustment will be applied on each anniversary of the date the employee started to receive Long-Term Disability benefit payments, 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 the benefit payment cannot exceed 3%. In the event of deflation, Sun Life will not decrease the benefit payment.		
Elimination period	182 days		
Maximum benefit period	The period ending on the last day of the month in which you reach age 65 Benefits may also end on an earlier date as specified in the *Long-Term Disability* section of this booklet		
Change in options	You can change your option during the *enrolment period* or within 31 days of a *life event change*. Proof of good health is required when the change is not during the enrolment period or not within 31 days of a life event change. The employee can only move up or down by one option at a time.		
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 it is paying all or a portion of the premium for this disability plan. Therefore, the benefit payments are taxable income.	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.	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 103441

Employee Basic Life

Amount	$25,000
Reduction	Coverage is reduced to 50% of the above amount when you reach age 70 If you continue, or begin, to work after having reached age 70, we calculate the amount for which you would have been eligible if you had not already reached age 70, then, we apply the above reduction clause to calculate the amount for which you are eligible.
Termination	When you retire

Employee Optional Life

Amount	You can choose coverage in units of $10,000
Overall maximum	$500,000 for basic and optional combined
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, whichever is earlier

Supplemental Life

	Option A	Option B
Amount	1 times your annual basic earnings, rounded to the nearest $1,000.The maximum amount of coverage is $400,000	2 times your annual basic earnings, rounded to the nearest $1,000.The maximum amount of coverage is $825,000

	Option A	Option B
Proof of good health	None	Required for coverage in excess of $800,000, 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 at age 70 to a maximum of $100,000	
Change in options	You can change your option during the *enrolment period* or within 31 days of a *life event change*. Proof of good health is required when the change is not during the enrolment period or not within 31 days of a life event change.	
Termination	When you retire	

Basic Dependent Life

Amount	Spouse – $5,000 Child – $2,500
Termination	When you retire

Spouse Optional Life

Amount	You can choose coverage in units of $10,000 Maximum – $500,000
Proof of good health	Approval required on the initial optional amount of coverage 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	$5,000 per child
Proof of good health	Approval required on the initial optional amount of coverage, unless enrolment is made within 31 days of the eligibility date, and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, whichever is earlier

Employee Assistance Program

Included

Making Claims

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.
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.

Type of claim	Starting the claims process	Limits and special instructions
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 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.

Classes	This booklet describes the coverage for the following classes of employees: • Class 1A – All Participants residing in Alberta • Class 1B – All Participants residing in British Columbia • Class 1M – All Participants residing in Manitoba • Class 1N – All Participants residing in New Brunswick • Class 1O – All Participants residing in Ontario • Class 1Q – All Participants residing in Quebec • Class 1S – All Participants residing in Saskatchewan
Your group benefits	The contract holder, Mitel Networks Corporation, self-insures the following benefits: • Extended Health Care • Emergency Travel Assistance • Dental Care • Health Spending Account This means Mitel Networks Corporation has the sole legal and financial liability for the benefits listed above 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, other than an Executive, 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 for at least 12 months. For employees residing in Québec, there is no minimum cohabitation period if a child is born out of the 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 25 (age 26 for employees residing in Québec) 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, Dental Care and Long-Term Disability, you must elect one of the options of coverage described in the 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 Core coverage. You may also elect one of the options of coverage for Supplemental Life as described in the Benefit Summary.

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.

If your enrolment request for Dental Care coverage is not received within 31 days of becoming eligible to receive it a late applicant maximum applies.
If your enrolment request for dependent coverage is not received within 31 days of becoming eligible to receive it – You will have to provide proof of good health at your own expense.

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 Optional Life
- Employee Supplemental Life
- Spouse Optional Life
- Child Optional Life

When coverage begins	Your coverage begins:
	• for Dental Care, **on the later of** the following dates:
	  • the date you become eligible for coverage.
	  • the date you enrol for coverage.
	• for all other benefits, on the date you become eligible for coverage.
	
	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.
	• the date Sun Life approves the dependent's proof of good health, if required.
	
	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 *enrolment period* or within 31 days of a *life event change*, a change in options takes effect on: • for changes requested during the *enrolment pe*riod, January 1 • for changes requested due to a *life event change,* the date the request is received but not before the actual date of the *life event change*. 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 1-866-896-6976.
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 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.
Basic earnings	Basic earnings are the salary you receive from your employer including any bonus or overtime earned on a regular basis, but excluding any incentive pay. If you are a commissioned salesperson, basic earnings are your average commissions over the past 2 years. If employed less than 2 years, basic earnings are your average commissions since your date of hire.

Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Enrolment period	The period every 2nd year, as determined by the contract holder, during which you can change your election of benefits.
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. • separation. • loss of spouse's benefit coverage. • death of a dependent.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Extended Health Care

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.

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.

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. • vaccines. • contraceptives, other than oral contraceptives. • products to help you quit smoking. • drugs for the treatment of sexual dysfunction. • 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.
Smoking cessation products	For employees residing in Québec, smoking cessation products are covered in accordance with the requirements under the Québec drug insurance plan.
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.

Out-of-pocket maximum	For employees residing in Québec, expenses incurred for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary and not reimbursed under this plan as a result of the application of the deductible or the reimbursement percentage are limited in each calendar year to the yearly maximum contribution set by the RAMQ plan. There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the employee.
Persons age 65 or over residing in Québec	Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the public prescription drug insurance plan of the Régie de l'assurance-maladie du Québec (RAMQ), which provides basic coverage for prescription drug costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be covered by either the public plan or your group plan. If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium. On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact your benefits administrator to clarify your situation. Unfortunately, we cannot change your file without confirmation from your benefits administrator.

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. After January 1st coincident with or next following your 65th birthday or your dependent's 65th birthday, the lifetime maximum is $25,000 per person
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	$250 per person, per lifetime
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 over 2 benefit years

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	2 pairs per person per benefit year
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	2 pairs per person per benefit year
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	one pair per person per benefit year
Hearing aids	Batteries are not covered	$1,200 per person over 4 benefit years Repairs are included in this maximum
Oxygen		
Blood glucose monitors		$700 per person, per lifetime
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	
Homeopathic drugs and naturopathic drugs and remedies	Must be prescribed by a registered naturopath	
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.

Covered expenses	Details	Payment limits
Visual training		Up to the reimbursement level indicated in the Benefit Summary
Vision care		
Contact lenses, eyeglasses, laser eye correction surgery or 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 if visual acuity in the better eye cannot be improved to at least 20/40 with eyeglasses. A letter of verification is required. 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.

Best Doctors

The services offered by Best Doctors are not insured or administered by Sun Life.

If you, as an employee, are covered for Extended Health Care, you, your spouse, your children, your parents and your parents-in-law have access to Best Doctors.

Best Doctors services are available to your spouse and children even if they are not covered for Extended Health Care under this plan.

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition. To learn more about Best Doctors services, or to use these services, please call Best Doctors at 1-877-419-BEST (2378).

Liability and responsibility of Sun Life

Sun Life will not be held liable for any acts or omissions of any person or organization providing services directly or indirectly in connection with Best Doctors.

Sun Life cannot guarantee the availability of Best Doctors services.

Emergency Travel Assistance

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.

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 1-866-896-6976. 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

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.

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 expenses**. 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.

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.

Restriction on payments	If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum amount we will pay is the *late applicant maximum* 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 36 months. • 1 recall examination every 5 months, up to 2 examinations per benefit year. • emergency or specific examinations.
X-rays	• 1 complete series of x-rays or 1 panorex every 36 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. • 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*).
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 8 units of 15 minutes per benefit year. • 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.
Rebase or reline	• rebase or reline of an existing partial or complete denture.
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.	
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 Option A.
- 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

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.

Long-Term Disability

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 80% (85% for Option B) 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.

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.

Sun Life will not pay benefits if you become totally disabled within 1 year 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 not been treated for the condition by a doctor or any medical personnel under the direction of a doctor within 90 days prior to the date you became covered for the Long-Term Disability benefit.

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

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** 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. This limitation also applies to your Supplemental Life.
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.

Employee Assistance Program

General description of the program

The Employee Assistance Program (***EAP***) available through your employer as part of your group benefits, gives you access to services performed by Morneau Shepell Ltd. (***Shepell***). The EAP is not insured by Sun Life. Sun Life only acts as administrator on behalf of the contract holder in providing access to the services available under the EAP.

In this section, *you* means the employee and all dependents as defined under the group plan.

Immediate, confidential help

Your EAP is a confidential and voluntary support service that can help you with:

- Family and social relationships
- Personal problems
- Dependency issues
- Workplace related issues
- Legal and financial advice*
- Wellness issues
- Crisis

*(does not include employment or workplace issues, criminal law, asset management or accounting services)

When you call Shepell, your needs will be assessed and a personal support plan will be designed. Your EAP includes:

- Clinically appropriate number of telephone sessions per issue
- Access to e-counselling, First Chat (online secure messaging), MyMigo, video counselling, online group counselling
- Unlimited access to online tools and resources on the EAP website
- Clinically appropriate number of in-person counselling sessions per issue

Assistance is available 24 hours a day, seven days a week. For immediate confidential help, you can call Shepell toll-free at 1-855-544-7722.

You can also access EAP services at www.workhealthlife.com/sunlife

Confidential service

Your EAP is completely confidential. Your employer will not be advised that you have used the service unless you choose to tell them.

Cost

There is no cost to use EAP and no claims to submit.

Liability of Sun Life or Shepell

Neither Sun Life nor Shepell will be held liable for any acts or omissions of any person or organization providing services in connection with this program.

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,
a member of the Sun Life Financial group of companies.

GB10171-E

Sun Life Financial