Sun Life Financial

# your group benefits

technicolor

## Contractual employees of Technicolor Canada, Inc.

**Contract Number 100556 and EAP**
**Effective May 1, 2021**

The Employee Assistance Program (EAP) is provided by Shepell.fgi

# Table of Contents

# Benefit Details

In this section, you will find the options which are available to you under each benefit. For more information on each benefit, please refer to the appropriate section in this booklet.

### Your Extended Health Care options

| | Basic | Standard |
|---|---|---|
| **Deductible** | Prescription drugs – $5 per prescription or refill<br>For all other expenses: None | Prescription drugs – $3 per prescription or refill<br>For all other expenses: None |
| | For employees residing in Québec, the prescription drug deductible ceases to be applied for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached. | |
| **Prescription drugs** | 80% after the deductible | 80% after the deductible |
| | 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. | |
| ***Drug substitution limit*** | Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your 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 Sun Life specifically approved the charges for the higher priced drug. | |
| | For employees residing in Québec, any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet the requirements. | |
| **Hospital expenses in your province** | 100%<br>semi-private room | 100%<br>semi-private room |

| | Basic | Standard |
|---|---|---|
| **Expenses out of your province** | Emergency – 100% | Emergency – 100% |
| **Medi-Passport** | Covered | Covered |
| **Private duty nursing** *(Max. per benefit year)* | Not covered | 80%<br>$15,000 per person |
| **Medical services and equipment** | 75% | 80% |
| ***Diagnostic services rendered outside of a hospital*** | Laboratory tests, ultrasounds, MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services – combined maximum of $500 per person per benefit year | Laboratory tests – no maximum<br><br>Ultrasounds – no maximum<br><br>MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services – combined maximum of $1,000 per person per benefit year |
| **Paramedical services** | Not covered | 80% |
| ***Licensed psychologist*** | Not covered | $750 per person<br>in a benefit year |
| ***Licensed chiropractors*** | Not covered | $500 per person<br>in a benefit year |
| ***Licensed physiotherapists, physical rehabilitation therapists, occupational therapists or athletic therapists*** | Not covered | Combined maximum of $750 per person per benefit year |
| ***All other paramedical services*** | Not covered | $500 per person<br>per benefit year per specialty |
| **Vision care** | Not covered | 80% |

| | Basic | Standard |
|---|---|---|
| ***Contact lenses, eyeglasses or laser eye correction surgery*** *(Max. per 24 months/ per 12 months if under 18)* | Not covered | $300 per person |
| ***Services of an ophthalmologist or licensed optometrist*** *(Max. per 12 months)* | Not covered | $75 per person |
| ***Overall maximum*** | Out-of-Canada emergency services – lifetime maximum of $3,000,000 per person, or, if lower, any other applicable lifetime maximum<br>All other expenses – none | |
| ***Lock-in period*** | 2 years | 2 years |
| ***Benefit year*** | January 1 to December 31 | |
| ***Changes in options*** | Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. Proof of good health is not required. | |
| ***Coverage ends*** | When you retire. Coverage may also end on an earlier date, as specified in *General Information*. | |

## Your Dental Care options

| | Basic | Standard |
|---|---|---|
| ***Preventive*** | Not covered | 100% |
| ***Basic*** | Not covered | 80% |
| ***Major*** | Not covered | 60% |
| ***Deductible*** | N/A | N/A |
| ***Benefit year maximum*** | N/A | $1,500 per person |
| ***Lock-in period*** | N/A | 2 years |
| ***Benefit year*** | January 1 to December 31 | |
| ***Changes in options*** | Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. Proof of good health is not required. | |
| ***Coverage ends*** | When you retire. Coverage may also end on an earlier date, as specified in *General Information*. | |

## Basic Life coverage

| | Basic | Standard |
|---|---|---|
| ***Coverage*** | $10,000 | 1 times your annual basic earnings rounded to the next higher $1,000 |
| ***Maximum*** | N/A | $1,000,000 for your basic and optional benefits combined |
| ***Coverage reduces*** | To 50% at age 65 | Coverage is reduced to a maximum benefit of $100,000 when you reach age 70 |
| ***Proof of good health*** | N/A | Approval required for coverage in excess of $600,000, and any increase in that coverage of 25% or more or $500, whichever is greater |
| ***Coverage ends*** | When you retire. Coverage may also end on an earlier date, as specified in *General Information*. | |
| ***Changes in options*** | You can change your selection during the annual enrolment period or within 31 days of a life event change. Proof of good health is required if you wish to increase coverage. | |

## Your Optional Life coverage

| | |
|---|---|
| ***Coverage*** | As elected by the employee, units of $10,000 |
| ***Maximum*** | $1,000,000 for your basic and optional benefits combined |
| ***Proof of good health*** | Approval required when you request optional coverage and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility |
| ***Coverage ends*** | When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. |

## Basic Accidental Death and Dismemberment coverage – Core Benefit

| | |
|---|---|
| ***Coverage*** | Equal to Employee Basic Life coverage |
| ***Coverage ends*** | When you retire. Coverage may also end on an earlier date, as specified in *General Information*. |

# General Information

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

## About this booklet

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.

Your group benefits may be modified after the effective date of this booklet. You will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

If you have any questions about the information in this employee benefits booklet, or you need additional information about your group benefits, please contact your employer.

## Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a contract employee working in Canada and have a contract or series of contracts with your employer for a combined minimum of 9 months of continuous employment.
- you are actively working for your employer at least 20 hours a week.
- you have completed the waiting period.

The waiting period for your group plan is 3 months of continuous employment.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the

scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. 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 a resident of Canada or the United States.

Your spouse:

- by marriage.
- under any formal union recognized by law.
- of the opposite sex or of the same sex who has been publicly represented as your spouse and with whom you have been cohabiting for at least 1 year, is an eligible dependent.

  For employees residing in Québec, there is no minimum cohabitation period if a child is born out of your relationship.

  Any separation of more than 3 months entail the loss of the designation of spouse.

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 not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, we will continue coverage as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

In these cases, you must notify Sun Life within 31 days of the date the child attains the limiting age. Your employer can give you more information about this.

**Enrolment**

You must choose the same option for the Extended Health Care and Dental Care benefits.

To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer within 31 days after the date you become eligible. If your enrolment request is not received by your employer within the 31 day period, you will be covered under the ***Basic*** Option for all benefits.

For a dependent to receive coverage, you must request dependent coverage.

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for Extended Health Care or Dental Care coverage under this plan within 31 days of the date the comparable coverage ends.

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

**When coverage begins**

Your coverage begins 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.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

Once you have dependent coverage, any subsequent dependents will be covered automatically.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

### Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

For a commissioned salesperson, any change in coverage resulting from a change in basic earnings will take effect on the following May 1. If the earnings change takes effect on May 1, then the change in coverage will take effect on that same day.

For changes requested due to a *life event change*, subject to the exceptions below, the change in coverage is effective on the date the request is received but not before the actual date of the *life event change*.

The following exceptions apply if the result of the change is an increase in coverage:

- 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 the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

### 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

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

### When coverage ends

As an employee, your coverage will end on the earlier of the following dates:

- the date your employment ends or you retire.

- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract 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 termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the Benefit Details section of this employee benefits booklet.

However, if you die while covered by this plan, coverage for your dependents will continue, without 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 the benefit provision under which the dependent is covered terminates.

**Replacement coverage**

The group contract will be interpreted and administered according to all legislation concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

If such legislation requires that Sun Life resume paying certain benefits

because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

**Making claims**

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

**Legal actions**

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.

**Proof of disability**

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

**Coordination of benefits**

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, our benefits will be coordinated with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

The plan that does not contain a coordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a coordination of benefits clause.

For dental accidents, health plans with dental accident coverage pay benefits before dental plans.

The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

Where both plans contain a coordination of benefits clause, claims must be submitted in the order described below.

***Claims for you and your spouse should be submitted in the following order:***

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order applies:
  - the plan where the person is covered as an active full-time employee.
  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

***Claims for a child should be submitted in the following order:***

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with 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.

- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

The above order applies in all situations except when parents are separated/divorced and there is no joint custody of the child, in which case the following order applies:

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.
- the plan of the parent not having custody of the child.
- the plan of the spouse of the parent not having custody of the child.

When you submit a claim, you have an obligation to disclose to Sun Life all other equivalent coverage that you or your dependents have.

Your employer can help you determine which plan you should claim from first.

**Medical examination**

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.

**Recovering overpayments**

We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

**Definitions**

Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions 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.

***Basic earnings***

Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.

If you are a commissioned salesperson and have been employed for at

least one calendar year, basic earnings are the earnings reported on your previous year's T4 income tax slip, including commissions. If you have been employed less than one calendar year, basic earnings are your estimated annual earnings based on your actual earnings, including 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 enrolment period is every two years as determined by your employer.

***Illness*** An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

***Life event change***

- Life event changes include:
- marriage or any other formal union recognized by law, or common-law,
- birth or adoption of a child,
- divorce or legal separation,
- loss or gain of benefit coverage under a spouse’s plan, or
- death of a dependent.

***Lock-in period*** The minimum time that you must remain with your chosen option. The lock in period is two years, unless you experience a *life event change*.

***Retirement date*** If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

***We, our and us*** We, our and us mean Sun Life Assurance Company of Canada.

# Extended Health Care
## (Medicare Supplement)

**General description of the coverage**

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. 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 in the treatment of an illness in accordance with Canadian medical standards.

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

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

**Benefit year**

The benefit year is indicated in the Benefit Details section.

**Deductible**

The deductible is indicated under each option in the Benefit Details section.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan

## Prescription drugs

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*.

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. The reimbursement level is indicated under each option in the Benefit Details section.

- 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 and oral contraceptives that legally require a prescription.
- intrauterine devices (IUDs), diaphragms, contraceptive patches and contraceptive delivery systems, up to a combined maximum of 1 item per person every 24 months.
- colostomy supplies.
- varicose vein injections, up to a maximum of $20 per visit.

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period.

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.
- products to help you quit smoking.
- drugs for the treatment of infertility.
- vaccines.
- 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

conditions(s).

- plan sustainability.

***Pharmaceutical services (rendered by pharmacists)***

For employees residing in Québec, we will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

***Prior authorization program***

The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.

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.

Our prior authorization forms are available from the following sources:

- our website at www.mysunlife.ca/priorauthorization

- our Customer Care centre by calling toll-free 1-800-361-6212

***Reference Drug Program***

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category*.

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.
- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete

and submit an exception form.

***Other health professionals allowed to prescribe drugs***

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

**Hospital expenses in your province**

We will cover the costs for hospital care in the province where you live. The reimbursement level is indicated under each option in the Benefit Details section.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and the hospital room indicated under each option in the Benefit Details section.

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.

**Expenses out of your province**

We will cover emergency services while you are outside the province where you live. The reimbursement level and the maximum amount we will pay are indicated under each option in the Benefit Details section.

For emergency 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.

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you live, subject to the reimbursement level and all conditions applicable to

those expenses.

***Emergency services***

We will only cover emergency services obtained within 90 days of the date you leave the province where you live. 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 management program that existed prior to the person leaving the province where the person lives.

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when you are 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.

/

**Medical services and equipment**

We will cover the costs for the medical services listed below when ordered by a doctor (the services of a dentist do not require a doctor's order). The reimbursement level is indicated under each option in the Benefit Details section.

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. 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 can not perform the duties. The reimbursement level and the maximum amount we will pay per person are indicated under each option in the Benefit Details section.
- transportation in a licensed ambulance, if medically necessary,

that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses, up to the maximum amount indicated under each option in the Benefit Details section:

  - laboratory tests.

  - ultrasounds.

  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services.

- 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. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.

- contact lenses or intraocular lenses following a cataract surgery, up to a lifetime maximum of $150 per person.

- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical

needs. Electric wheelchairs, scooters, inhalation appliances, mechanical or hydraulic lifts and repairs to hospital beds are not covered.

- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery.
- artificial limbs and eyes, excluding myoelectric appliances.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a combined maximum of $400 per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $300 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, up to a combined maximum of $4,000 per person per benefit year. You must provide us with a doctor's note confirming the diagnosis.

**Paramedical services**

We will cover the costs for paramedical specialists listed below. The reimbursement level and the maximum amount we will pay are indicated under each option in the Benefit Details section.

- licensed psychologists.
- licensed massage therapists.

- licensed speech therapists.
- licensed physiotherapists, occupational therapists, athletic therapists or athletic therapists who are active members of the Canadian Athletic Therapists Association (CATA) or of a provincial association approved by Sun Life, physical rehabilitation therapists, or physical rehabilitation therapists who are active members of the Ordre professionnel de la physiothérapie du Québec or of a provincial association approved by Sun Life.
- licensed naturopaths.
- licensed osteopaths or osteopathic practitioners, including x-ray examinations. The cost of x-ray examinations is not included in the benefit year maximum.
- licensed chiropractors, including x-ray examinations. The cost of x-ray examinations is not included in the benefit year maximum.
- licensed podiatrists or chiropodists, including x-ray examinations. The cost of x-ray examinations is not included in the benefit year maximum.

We will not pay for the cost of services rendered by a podiatrist in Ontario and Alberta unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

**Vision care**

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery and the services of an ophthalmologist or licensed optometrist.

Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

The reimbursement level and the maximum amounts we will pay are indicated under each option in the Benefit Details section.

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.

**Payments after coverage ends**

If you are totally disabled 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.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed 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 *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).

- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- 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.

**Integration 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 that portion of the expense that is not payable or available under the government program, regardless of:

- whether you have made an application to the government program,
- whether coverage under this plan affects your eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer.

In order for you to receive benefits, we must receive the claim no later than:

- 458 days after the date you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage, whichever is earlier.

# Emergency Travel Assistance

## General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (*Allianz Global Assistance*) can help.

*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. It only covers emergency services that you obtain within 90 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

The Medi-Passport coverage is subject to any maximum applicable to the emergency portion of the Extended Health Care benefit. The emergency services excluded from coverage, and all other conditions, limitations and exclusions applicable to your Extended Health Care coverage also apply to Medi-Passport.

We recommend that you bring your Travel card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.

## Getting help

**At the time of an emergency, you or someone with you must contact Allianz Global Assistance. If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.**

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; or
- for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

If necessary, in the case of such a child, Allianz Global Assistance will also make arrangements and advance funds for a qualified attendant to accompany them home. The attendant is subject to the approval of you or a member of your family.

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 place where you are hospitalized if you are hospitalized for more than 7 consecutive days, and:

- you are travelling alone, or

- you are travelling only with a child who is under the age of 16 or mentally or physically handicapped.

We will pay a maximum of $150 a day for the family member's meals and accommodations at a commercial establishment up to a maximum of 7 days.

**Repatriation**

If you die while out of the province where you live, Allianz Global Assistance will arrange for all necessary government authorizations and for the return of your remains, in a container approved for transportation, to the province where you live. We will pay a maximum of $5,000 per return.

**Vehicle return**

Allianz Global Assistance will arrange and, if necessary, advance funds up to $500 for the return of 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 returning the vehicle.

**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 attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

**Coordination of coverage**

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and Allianz Global Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Allianz Global Assistance will ask you to sign a form authorizing them to act on your behalf.

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.

**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.

The maximum amount advanced will not exceed $10,000 per person per trip unless this limit will compromise your medical care.

**Reimbursement of expenses**

If, after obtaining confirmation from Allianz Global Assistance that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.

To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.

**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. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

**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 your departure.

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 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**

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

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

For each dental procedure, we will only cover reasonable and customary charges. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

*Reasonable and customary charges* mean:

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

When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

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.

An expense must be claimed for the benefit year in which the expense is incurred. 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.

**Benefit year**

The benefit year is indicated in the Benefit Details section.

**Benefit year maximum**

The maximum amount we will pay per person per benefit year is indicated under each option in the Benefit Details section.

**Predetermination**

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should 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.

**Preventive dental procedures**

Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

The reimbursement level is indicated under each option in the Benefit Details section.

***Oral examinations***

1 complete examination every 12 months.

1 recall examination every 6 months.

Emergency or specific examinations.

***X-rays***

1 complete series of x-rays or 1 panorex every 12 months.

1 set of bitewing x-rays every 6 months.

X-rays to diagnose a symptom or examine progress of a particular

course of treatment including sialography and radiopaque dyes to demonstrate lesions.

***Other services*** Required consultations between two dentists.

Polishing (cleaning of teeth) treatment once every 6 months.

Topical fluoride treatment once every 6 months. Only children under age 18 are covered for these procedures.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Oral hygiene instruction once every 6 months.

Habit breaking appliances.

**Basic dental procedures**

Your dental benefits include the following procedures used to treat basic dental problems.

The reimbursement level is indicated under each option in the Benefit Details section.

***Fillings*** Amalgam, composite, acrylic or equivalent.

***Extraction of teeth*** Removal of teeth.

***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*** Treatment of disease of the gum and other supporting tissue.

For scaling and root planing, up to a combined maximum of 2 units of 15 minutes per benefit year for a child under age 13 or 10 units of 15 minutes per benefit year for any other person.

***Oral surgery*** Surgery and related anaesthesia including removal of impacted teeth

(*Preventive dental procedures*) and implant related surgery (*Major dental procedures*).

***Repair*** Repair of bridges or dentures.

***Rebase or reline*** Rebase or reline of an existing partial or complete denture.

***Other services*** Recementation and removal of inlays, onlays or crowns.

Provision of space maintainers for missing primary teeth. Only children under age 18 are covered for these procedures.

Pit and fissure sealants.

## Major dental procedures

Your dental benefits include the following procedures used to treat major dental problems.

The reimbursement level is indicated under each option in the Benefit Details section.

***Major restorations*** Inlays and onlays other than their recementation and removal (*Basic dental procedures*).

Crowns and repairs to crowns, other than their recementation and removal and prefabricated metal restorations (*Basic dental procedures*).

***Prosthodontics*** Construction and insertion of bridges or standard dentures. Coverage is limited to teeth extracted while you are covered under this plan. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

- it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.
- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

***Implants*** Implants, including surgery charges, subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant.

**Payments after coverage ends**

If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed 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:

- hand and wrist examinations (as diagnostic aid for dental treatment) and postero-anterior and lateral skull and facial bone survey films.
- 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.
- 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.

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive a claim no later than:

- 458 days after the date you incur the expenses, or
- 90 days after the end of your Dental Care coverage, whichever is earlier.

We can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any additional information that we consider necessary.

# Life Coverage

**General description of the coverage**

Your Life coverage provides a benefit for your beneficiary if you die while covered.

**What we will pay**

The amounts of coverage are indicated in the Benefit Details section.

**Who we will pay**

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid 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.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and desire to designate a minor as your beneficiary, you may wish to designate someone else to receive the death benefit in trust for the minor. If a trustee is not designated, applicable legislation may require that a death benefit payable to a minor be paid instead to a court, or guardian or public trustee. If you reside in Québec and have designated a minor as beneficiary, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively (and regardless of whether you reside outside or in Québec), you may wish to consider designating your estate as beneficiary and provide the executor(s) with directions in your will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

**Suicide**

If you 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 have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

**Coverage during total disability**

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for at least an uninterrupted period of 6 months.

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience.

**Living Benefits Loan Program**

If you are terminally ill with a life expectancy of 24 months or less, you may apply for a commercial loan under the Sun Life Living Benefits Loan Program. Under this program, you may receive an advance of up to 50% of your Basic Life coverage, to a maximum of $50,000.

If you are within 5 years of a scheduled reduction of your Basic Life coverage, the advance you may receive cannot exceed 50% of the lowest reduced amount of your Basic Life coverage. If you are within 5 years of the termination of your Basic Life coverage, you may not apply for a commercial loan under the Sun Life Living Benefits Loan Program. This program is subject to other restrictions. Please contact your employer for details.

### Converting Life coverage

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

The request must be made within 31 days of the reduction or end of the Life coverage.

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.

### When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

# Accidental Death and Dismemberment

**General description of the coverage**

Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you die or suffer any of the losses listed in the table under *What we will pay*. Any death benefit paid under this coverage is in addition to the Life coverage.

**What we will pay**

The amount of coverage is indicated in the Benefit Details section.

We will pay for this benefit if you:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you are still alive.
- are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages we use to determine the payment.

**TABLE OF LOSSES**

| | |
|---|---|
| Loss of life | 100% |
| Loss of both arms or both legs | 100% |
| Loss of both hands or both feet | 100% |
| Loss of one hand and one foot | 100% |
| Loss of one hand or one foot, and entire sight of one eye | 100% |
| Loss of one arm or one leg | 75% |
| Loss of one hand or one foot | 75% |

| | |
|---|---|
| Loss of four fingers on the same hand | 33 1/3% |
| Loss of thumb and index finger on the same hand | 33 1/3% |
| Loss of four toes on the same foot | 25% |
| Loss of use of both arms or both legs | 100% |
| Loss of use of both hands or both feet | 100% |
| Loss of use of one arm or one leg | 75% |
| Loss of use of one hand or one foot | 75% |
| Loss of entire sight of both eyes | 100% |
| Loss of speech and loss of hearing in both ears | 100% |
| Loss of entire sight of one eye | 75% |
| Loss of speech | 75% |
| Loss of hearing in both ears | 75% |
| Loss of hearing in one ear | 25% |
| Quadriplegia | 200% |
| Paraplegia | 200% |
| Hemiplegia | 200% |

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. We will not pay more than 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay a maximum of 200%.

Loss of an arm means that it was severed at or above the elbow. Loss of a hand means that it was severed at or above the wrist. Loss of a leg means that it was severed at or above the knee. Loss of a foot means that it was severed at or above the ankle. Loss of a thumb, finger or toe means that it was severed at or above the first joint from the hand or foot. Loss of sight, speech or hearing must be total and permanent.

Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

**Limit on benefit amounts**

If more than one person covered by the group contract is eligible for

benefits resulting from the same accident, Sun Life will pay up to a maximum of $3,000,000 for all claims related to the accident.

If the total amount of benefits payable for the accident is more than $3,000,000, then we will pay for each person a percentage of the $3,000,000 that is equal to the percentage the person would have received of the total payable.

**Repatriation benefit**

If you die as a direct result of an accident 100 kilometres or more from home, we will pay up to $10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.

**Rehabilitation program**

If you suffer a loss, other than a loss of life, we will pay up to $10,000 of your rehabilitation expenses. We will only pay for the usual and reasonable expenses connected with a rehabilitation program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the rehabilitation program and the expenses must be incurred within 3 years of the accident and while you are covered for this benefit. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the rehabilitation program will be based on the likelihood that it will be successful. The rehabilitation will be made up of training required, because of the loss, to prepare you for a new occupation.

**Spouse occupational training benefit**

If you die as a direct result of an accident, we will pay up to $5,000 to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the expenses and all expenses must be incurred within 3 years of the date of the accident. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the training program will be based on the likelihood that it will be successful.

**Child education benefit**

If you die as a direct result of an accident, we will pay for a dependent child's tuition fees in a post-secondary school. We will pay the child 5% of the amount of coverage up to $5,000, each year up to a maximum of 4 years. The child must enrol as a full-time student within one year of your death.

We will only pay for the usual and reasonable tuition expenses. This does not include ordinary living expenses such as room, board, travelling or clothing. This also does not include education expenses incurred prior to your death.

**Family transportation benefit**

If you suffer a loss as a direct result of an accident and are hospitalized at least 150 kilometres from home, we will pay up to $5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister.

We will only pay for the usual and reasonable travel expenses. We will pay for car travel at a rate of $0.20 per kilometre. Transportation must be by the most direct route to and from the hospital. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

**Coverage during total disability**

If you become totally disabled while covered and premiums are no longer payable for Life coverage, this Accidental Death and Dismemberment coverage will continue without the payment of premiums, but not beyond age 65, for as long as premiums are not payable for your Life coverage.

Any amount of coverage continued is subject to the terms of this group plan when total disability began.

**What is not covered**

We will not pay for losses that are the result of:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.
- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- flying in, descending from or being exposed to any hazard related to an aircraft while
  - receiving flying lessons.
  - performing any duties in connection with the aircraft.
  - being flown for a parachute jump.
  - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence.

**Converting coverage**

If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to

convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy.

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.

### When and how to make a claim

For any loss other than death, the claim must be received by Sun Life within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

# Employee Assistance Program

**General description of the program**

This program is provided by Shepell.fgi. The Employee Assistance Program (EAP) is not insured or administered by Sun Life Assurance Company of Canada.

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

**Immediate, confidential help for any concern**

Your EAP is a confidential and voluntary support service that can help you address all types of problems and challenges in your life. In addition to providing you with support on health-related issues (such as stress, anxiety, depression, nutrition and addictions), EAP provides a range of support services relating to legal, financial, family and workplace issues.

You can receive support over the telephone, in person, online, and through a variety of issue-based health and wellness resources. For each concern you are experiencing, you can receive a series of sessions. You can also take advantage of online tools to help manage personal well-being. For a complete description of this service, please refer to your EAP brochure.

Assistance is available 24 hours a day, seven days a week. For immediate confidential help, you can call Shepell.fgi:

- toll-free at 1-866-347-2061
- TTY Service for the hearing impaired at 1-877-338-0275

You can visit online counselling at www.shepellfgi.com/ecounselling or online resources at www.shepellfgi.com.

**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. If you need more specialized or longer-term support, your EAP will help you select an appropriate specialist or service that can provide assistance. While fees for these additional services are your responsibility, some may be covered by your provincial plan or your group plan.

**Liability of Sun Life**

Sun Life will not 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).

**Need information ?**

**ONLINE: mysunlife.ca/technicolor**
**TELEPHONE: 1-866-896-6976**