Sun Life Financial

your group benefits

District of Fort St. James

All employees

Contract Number 175633
Effective October 1, 2023

Table of Contents

Benefit Summary

This is a general summary of the coverage provided under your group plan and should be read together with the information contained in your booklet. For more information, including exclusions, limitations and other conditions, please refer to the appropriate sections of your booklet.

General Information

Waiting Period	3 months of continuous employment
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of your booklet.

Extended Health Care

Benefit year	January 1 to December 31
Deductible	None
Drug card plan	Included
Reimbursement level	
Prescription drugs	80%
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 the covered person and the attending doctor to complete and submit an exception form.
In-province hospital	100% of the difference between the cost of a ward and a semi-private hospital room
Convalescent hospital	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 treatment of an illness due to the same or related causes

Out-of-province emergency services	100% Emergency Travel Assistance included Maximum of 60 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services
Out-of-province referred services	80%
Medical services and equipment	80%
Paramedical services	80% up to a maximum of $500 per person per specialty in a benefit year for the paramedical specialists listed below: ■ licensed psychologists or social workers ■ licensed massage therapists ■ licensed speech therapists ■ licensed physiotherapists ■ licensed naturopaths ■ licensed acupuncturists ■ licensed audiologists ■ licensed dieticians ■ licensed occupational therapists ■ licensed osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year ■ licensed chiropractors, including a maximum of one x-ray examination each benefit year ■ licensed podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year
Vision care	100% up to a maximum of $300 in any 12 month period for a person under age 18 or in any 24 month period for any other person
Teladoc Medical Experts services	Included
Lumino Health Virtual Care services	Included
Termination	When you retire or reach age 70, whichever is earlier

Dental Care

Benefit year	January 1 to December 31
Deductible	None
Fee guide	The current fee guide for general practitioners in the province where the employee lives
Reimbursement level	
Preventive procedures	100%
Basic procedures	100%
Major procedures	60%
Orthodontic procedures	50%, only for children under age 19
Maximum benefit	
Benefit year maximum	Preventive, Basic procedures and Major procedures – $1,000 per person TMJ and Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.
Lifetime maximum	TMJ procedures – $1,000 per person Orthodontic procedures – $5,000 per person
Late applicant maximum	If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum benefit is $300 per person during the first 3 years for Orthodontic procedures, and $100 per person during the first year for all other expenses
Termination	When you retire or reach age 70, whichever is earlier

Long-Term Disability

Maximum amount	66.67% of your monthly basic earnings up to a maximum of $7,500. For coverage in excess of the amount indicated under *Proof of good health,* your coverage is subject to approval by Sun Life. Refer to *Proof of good health* below for further information. The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Long-Term Disability* section of your booklet.
Tax status	Your employer has indicated that all or a portion of the premium for this disability plan is paid by the employer. Therefore, the benefit payments are taxable income.
Proof of good health	Approval required for coverage in excess of $4,500, and any increase in that coverage of 25% or more or $500, whichever is greater
Elimination period	4 months
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 your booklet
Termination	The day you reach age 65 less the elimination period or the day you retire, whichever is earlier

Critical Illness – Contract No. 131185

Employee Critical Illness

Amount	$10,000
Termination	When you retire or reach age 65, whichever is earlier

Life

Employee Life

Amount	$50,000
Reduction	Coverage is reduced to 50% of the above amount when you reach age 65

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

Dependent Life

Amount	Spouse – $5,000 Child – $2,500
Termination	When you retire or reach age 70, whichever is earlier
Converting Life coverage	If Life coverage ends or reduces for any reason other than your request, the group Life coverage may be converted to an individual Life policy with Sun Life without providing proof of good health. For more information, please refer to the *Life Coverage* section of your booklet.

Accidental Death and Dismemberment

Employee Accidental Death and Dismemberment

Amount	Equal to Employee Life coverage
Termination	When you retire or reach age 70, whichever is earlier

General Information

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.

For administrative purposes, number 131185 will be used for the Critical Illness benefit under this contract.

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 permanent employee working in Canada.
- you are actively working for your employer at least 20 hours a week.
- you have completed the waiting period. Any period during which you do not meet the above eligibility requirements cannot be counted as part of 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 or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. 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 25 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 have to enrol to receive coverage. To enrol, you must send the appropriate enrolment information to Sun Life through your employer. 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 plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

You should request coverage for yourself or your dependents within 31 days of becoming eligible for coverage. If your enrolment request is not received by Sun Life within this time limit, you will have to provide proof of good health at your own expense.

Proof of good health is required if you are age 65 or over on the date you become eligible for coverage unless you were covered under a previous group contract when it ended. Proof of good health is also required for your dependents.

There are other circumstances when you will be required to provide proof of good health. Please contact your employer for additional information as it may impact the amount of your coverage.

When coverage begins

Your coverage begins on the later of the following dates:

- the date you become eligible for coverage.
- the date you enrol for coverage.
- the date Sun Life approves your proof of good health, if required.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

A dependent's coverage begins on the later of the following dates:

- the date your coverage begins.
- the date the dependent becomes eligible for coverage.
- the date you request dependent coverage.
- the date Sun Life approves the dependent's proof of good health, if required.

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. However, for claims paying purposes, you must advise your employer of the name of any subsequent dependent.

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 could lead to a change in 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 April 1. If the earnings change takes effect on April 1, then the change in coverage will take effect on that same day.

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.

For Critical Illness coverage, to understand the impact on coverage when new covered conditions are added to this plan, refer to the Critical Illness benefit provision.

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 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 termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

Surviving dependent coverage

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 your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

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

Replacement coverage

The group contract will be interpreted and administered according to the guidelines of the Canadian Life and Health Insurance Association or any applicable 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 or guidelines require that Sun Life resume paying certain benefits because of a recurrence of your total disability, Sun Life will resume payment at the same amount subject to all terms and conditions of the group contract.

With respect to Critical Illness, for coverage for any covered condition which was not included in the previous group plan, refer to the Critical Illness benefit provision.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. For Critical Illness claims, you should contact Sun Life to get the proper form to make a claim. For all other claims, 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 examinations

We can require medical examinations of any person for whom a claim is made. We will pay for the cost of these examinations. If the person fails or refuses to have an 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.

Assignments

For Life benefits, no rights or interests can be assigned.

For all other benefits, we reserve the right to refuse assignments.

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.

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 excluding any bonus, overtime or incentive pay.

If you are a commissioned salesperson, basic earnings are your average earnings over the past 2 years, including commissions. If employed less than 2 years, basic earnings are your average earnings since your date of hire, including commissions.

Doctor A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

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

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

Extended Health Care

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.

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

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:

- 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 $2,400 for each person.
- vaccines.
- intrauterine devices (IUDs) and diaphragms up to a maximum of $500 per person in a benefit year.
- colostomy supplies.
- varicose vein injections.

We will cover 80% of the cost of the above drugs and supplies.

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.

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 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.

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.

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 100% of the costs for hospital care in the province where you live.

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 a semi-private hospital room.

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 100% of the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

The maximum amount payable is the difference between the cost of a ward and a semi-private room, up to $20 per day for a maximum of 180 days for treatment of an illness due to the same or related causes.

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

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, 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 pay 100% of the cost of covered emergency services.

We will only cover emergency services obtained within 60 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.

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. We will pay 80% of the costs of referred services. 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, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $3,000,000 per person or, if lower, any other applicable lifetime maximum.

Medical services and equipment

We will cover 80% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- 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 cannot perform the duties. There is a limit of $10,000 per person per benefit year.

- 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:
  - laboratory tests.
  - ultrasounds.
  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of $500 per person per benefit year.
- 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.
- services of an ophthalmologist or licensed optometrist, up to a maximum of $75 per person over 2 benefit years.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- wigs following chemotherapy, up to a maximum of $300 per person in a benefit year. Wigs do not require a doctor's order.

- 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. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- 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, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $300 per person in a benefit year.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $300 per person in a benefit year.
- hearing aids, up to a maximum of $500 per person over a period of 3 benefit years. Repairs are included in this maximum.
- oxygen, plasma and blood transfusions.
- blood glucose monitors, up to a lifetime maximum of $700 per person.
- Continuous Glucose Monitor (CGM), including receivers, transmitters and sensors, for persons diagnosed with Type 1 or Type 2 diabetes requiring insulin use, up to a combined maximum of $4,000 per person per benefit year. You must provide us with a doctor's note confirming both the diagnosis and insulin use.

Paramedical services

We will cover 80% of the costs, up to a maximum of $500 per person per specialty in a benefit year for the paramedical specialists listed below:

- licensed psychologists or social workers.
- licensed massage therapists.
- licensed speech therapists.
- licensed physiotherapists.
- licensed naturopaths.
- licensed acupuncturists.
- licensed audiologists.
- licensed dieticians.
- licensed occupational therapists.
- licensed osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year.
- licensed chiropractors, including a maximum of one x-ray examination each benefit year.
- licensed podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year.

Vision care

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery. 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.

We will cover 100% of these costs up to a maximum of $300 in any 12 month period for a person under age 18 or in any 24 month period for any other person.

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

Extended Health Care coverage will end when the employee retires or reaches age 70, whichever is earlier.

Coverage may also end on an earlier date, as specified in *General Information*.

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 or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

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

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

Teladoc Medical Experts

The services offered by Teladoc Medical Experts 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 Teladoc Medical Experts.

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

Teladoc Medical Experts offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition. To use this service, please call Teladoc Medical Experts at 1-877-419-2378.

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 Teladoc Medical Experts.

Sun Life cannot guarantee the availability of Teladoc Medical Experts services.

Lumino Health Virtual Care

The services offered through Lumino Health Virtual Care are provided by Dialogue. These services are not insured or administered by Sun Life.

If you are covered for Extended Health Care coverage, you and your covered dependents will have access to Dialogue services.

Lumino Health Virtual Care offers a variety of services including access to medical professionals. To learn more about the services provided by Dialogue, or to use these services, please visit https://luminovc.dialogue.co/.

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 Dialogue.

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 60 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:

- rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or act of God.
- 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 employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

If services are provided by a dental specialist, eligible expenses are limited to the fees indicated in the above fee guide for general practitioners.

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.

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.

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, except for orthodontic procedures where an expense is incurred for each appointment.

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than $1,000 per person for each benefit year for Preventive, Basic dental procedures and Major dental procedures combined.

TMJ and Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.

Lifetime maximum

The maximum amount we will pay for all TMJ procedures in a person's lifetime is $1,000.

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $5,000.

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 for all Orthodontic procedures is $300 per person for the first 3 years of coverage.

The maximum amount we will pay for all other eligible expenses is $100 per person for the first year.

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.

We will pay 100% of the eligible expenses for these procedures.

Oral examinations

You are covered for the following complete, recall or specific oral examinations. Any examination must be separated from any other examination by at least 6 months.

- 1 complete examination every 36 months. A complete examination includes complete examination and charting of the hard and soft structures, periodontal charting, pulp vitality tests, recording history, treatment planning, case presentation and consultation with the patient.
- 1 recall or specific examination every 6 months. Recall and specific examinations include a complete examination of the hard and soft structures, checking occlusion, pulp vitality tests and consultation with the patient.

You are also covered for 1 exam per specialty every 36 months and for emergency examinations.

- specialty examinations include general or specific examinations for periodontics, oral surgery, prosthodontics and endodontics.
- an emergency examination includes an evaluation for acute pain or infection, and pulp vitality tests.

X-rays

You are covered for all the following x-rays:

- 4 bitewing x-rays in any 6 month period. A bitewing x-ray is a routine check-up x-ray used to detect decay in molar teeth.

- 1 complete series of x-rays or 1 panorex every 36 months. A complete series of x-rays is 10-14 individual x-rays, including bitewings, showing all the teeth in the mouth. A panorex is a large panoramic view of the entire mouth.
- 4 x-rays of single teeth, called periapical x-rays, in any 60 day period.
- 2 occlusal x-rays in any 12 month period.
- 2 extra oral x-rays in any 12 month period.

Test and lab exams Test and lab examinations covered by this benefit include microbiological tests, histological tests and cytological tests.

Polishing **Cleaning of teeth.** Limited to 1 unit of 15 minutes of cleaning every 6 months.

Scaling and root planing **Tartar removal.** Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

You are covered for up to 10 units of 15 minutes of tartar removal in any 12 month period and a child under age 13 is covered for up to 2 units of 15 minutes of tartar removal in any 12 month period.

Topical fluoride treatment You are covered for 1 treatment every 6 months.

Oral hygiene instruction You are covered for 1 unit of 15 minutes of instruction every 36 months on how to brush and floss.

Disking **Filing or reshaping teeth.** Only children under 19 are covered for this procedure.

Space maintainers and maintenance You are covered for this procedure when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth.

You can only have 1 appliance per quadrant unless another tooth in that quadrant is subsequently lost. Teeth are divided into 4 quadrants: upper right, upper left, lower right and lower left.

This procedure includes the design, separation, fabrication, insertion, cementation, removal and 6 month follow-up care.

Maintenance includes adjustments and recementation, addition of clasps or activating wires, repairs and recementation, and 6 month follow-up care.

Caries, trauma and pain control

You are covered for sedative fillings that are applied to very deep cavities to reduce pain.

This procedure includes local anaesthesia, removal of decay or removal of existing restoration, occlusal adjustment, pulp cap and placement of a sedative filling.

Basic dental procedures

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

We will pay 100% of the eligible expenses for these procedures.

Fillings

You are covered for amalgam fillings (silver) and composite or acrylic fillings (white fillings).

An amalgam filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on one surface will be considered a single filling.

A composite or acrylic filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on one surface will be considered a single filling. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

Retentive pins

You are covered for up to 3 retentive pins (for amalgam and composite fillings) per tooth.

Pre-fabricated metal or plastic restorations

This coverage is only available when a permanent crown is not being installed. You are covered for pre-fabricated metal or plastic restorations, including stainless steel crown. Replacements must be separated by at least 36 months.

This procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, and cementation of crown.

Pit and fissure sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Only children under 19 are covered for this treatment. A child is covered for 1 treatment per permanent molar tooth.

Endodontics

Endodontics is root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

Root canal therapy. You are covered for 1 standard treatment per tooth every 5 years. This procedure includes treatment plan, pulp vitality test, opening and drainage, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, relieving occlusion, smoothing tooth, and follow-up care. If root canal therapy is performed on the same tooth by the same dentist within 3 months of opening and drainage, pulpotomy or pulpectomy, the amount payable is reduced by the amount previously paid for such opening and drainage, pulpotomy or pulpectomy.

Apexification. This procedure includes treatment plan, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, placement of dentogenic media, and follow-up care. You are only covered for permanent teeth.

Apicoectomy. This procedure includes treatment plan, local anaesthesia, clinical procedure with appropriate x-rays, root resection, apical curettage, and follow-up care.

Retrofilling. This procedure includes apicoectomy, curettage and root-end filling.

Root amputation. This procedure includes recontouring tooth and furca.

Hemisection. You are covered for this procedure.

Vital pulpotomy. This procedure includes treatment plan, local anaesthesia, clinical procedure and appropriate x-rays, and follow-up care.

Periodontics

Periodontics is the treatment of bone and gum disease.

Definitive periodontal surgery. If you have surgery, coverage depends on how many teeth are involved. You are covered for each type of surgery once every 12 months on the same surgical site.

Definitive periodontal surgery includes local anaesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant. The mouth is divided in 6 sextants. The allowance for fewer teeth may be prorated. Definitive periodontal surgery includes the following procedures:

- gingival curettage – definitive surgical procedure performed by the dentist under local anaesthesia. You are covered for 1 gingival curettage per site every 12 months.
- gingivoplasty. You are covered for 1 gingivoplasty per site every 12 months.
- gingivectomy. You are covered for 1 gingivectomy per site every 12 months.
- flap approach. You are covered for 1 flap approach surgery per site every 12 months.
- grafts – pedicle, free soft tissue, lateral sliding and rotated. This procedure includes local anaesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. You are covered for 1 graft per site every 12 months.

You are also covered for **additional periodontal surgery** which includes the following procedures:

- distal wedge procedure. This procedure includes local anaesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant. You are covered for 1 distal wedge procedure per site every 12 months.
- treatment of periodontal abscess or pericoronitis. This procedure includes lancing, scaling, curettage, medication, or surgery. You are covered for 1 unit of 15 minutes per treatment and 2 units of 15 minutes in any 12 month period.

You are also covered for **related periodontal services** which includes the following procedures:

- provisional splinting. This procedure includes tooth preparation, acid etch, wire replacement, acrylic or composite filling, occlusal adjustment, and 3 month follow-up care. You are covered for 1 unit of 15 minutes per joint. Replacements must be separated by at least 24 months.

- occlusal adjustment. You are covered for treatments to adjust your bite for 1 unit of 15 minutes for each office visit and 2 units of 15 minutes in any 12 month period. This treatment is only available when you have gum surgery or temporomandibular joint (TMJ) treatment.
- periodontal appliance. Includes impression, insertion and adjustments within 6 months of insertion. Replacements must be separated by at least 12 months. A periodontal appliance is used to treat gum disease.
- periodontal appliance adjustment or reline. You are covered for 1 unit of 15 minutes in any 12 month period.

Oral surgery

Oral surgery includes local anaesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation. A surgical site will be considered a sextant unless specified as a quadrant.

- extraction of erupted tooth – uncomplicated. Limited if additional teeth extracted in the same quadrant.
- extraction of erupted tooth – complicated. Limited if additional teeth extracted in the same quadrant. Surgery requires surgical flap or sectioning of the tooth.
- extraction of impacted tooth – soft tissue impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue and extraction of impacted tooth.
- extraction of impacted tooth – partial bone impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and either removal of bone and tooth or sectioning and removal of tooth.
- extraction of impacted tooth – complete bone impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and removal of bone and sectioning and removal of tooth.
- extraction of residual root. Limited if additional teeth extracted in the same quadrant.
- surgical exposure of impacted tooth. Limited if additional teeth exposed in the same quadrant.

- alveoloplasty. This procedure includes remodelling, excision, removal and reduction of bone.
- other procedures: stomatoplasty, remodelling mouth floor, vestibuloplasty, ridge reconstruction, and mucus fold extension; surgical excision of tumours; surgical excision of cysts; surgical incision and drainage; surgical removal of foreign body; repairs of lacerations; frenectomy; salivary gland treatment; and antral surgery.

Related surgical services

You are covered for the following services only when you have eligible complicated oral surgery:

- anaesthesia, including pre-anaesthetic evaluation and post-anaesthetic follow-up: general anaesthesia, deep sedation and provision of dental and anaesthetic facilities, equipment and supplies.
- conscious sedation: inhalation technique, intravenous sedation, intramuscular injections of sedative drugs; and combined techniques of inhalation plus intravenous or intramuscular injections.
- therapeutic injections: administration of intramuscular drug injections.

Repairing, relining or rebasing dentures

Repairing dentures means fixing broken or damaged dentures. This procedure includes 6 month follow-up care.

Relining dentures means adding material so that the dentures fit properly. Rebasing dentures means fitting dentures with a new base. You are covered for 1 reline or rebase in any 12 month period. These services include 6 month follow-up care.

Major dental procedures

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

We will pay 60% of the eligible expenses for these procedures.

Inlays, onlays and gold foil restorations

Inlays and onlays are metal or porcelain fillings placed on the surface of the tooth. Inlays, onlays or gold foil restorations are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage. Replacements must be separated by at least 5 years.

Inlays and onlays include treatment planning, occlusal records, local anaesthesia, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. Inlays are only covered when x-rays indicate a crown will be required. Onlays are limited to teeth with extensive incisal or cusp damage.

Gold foil restorations include treatment planning, local anaesthesia, removal of decay or old restoration, tooth preparation, pulp protection, insertion, occlusal adjustments, and gold material.

Crowns This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. It does not include porcelain or porcelain fused to metal for molar teeth. Crowns are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage. Replacements must be separated by at least 5 years.

Veneers Veneers are white facings put on the front of the tooth's surface. Veneers are only covered for teeth that cannot be restored with a regular filling as long as they are not used primarily to improve appearance. Replacements must be separated by at least 36 months.

Dentures **Full dentures.** Replacements must be separated by at least 5 years.

- standard dentures. This procedure includes treatment plan, initial and final impressions, jaw relations records, try-in insertion, occlusal equilibration, and follow-up care and adjustments for 6 months following insertion.
- standard immediate dentures. This procedure includes treatment plan, impressions, jaw relations records, tissue conditioner, insertion, occlusal equilibration, and follow-up care and adjustments for 6 months following insertion.

Partial dentures. Replacements must be separated by at least 5 years. This procedure includes treatment plan, mouth preparation, initial and final impressions, jaw relations records, connectors, rests, clasps, and bases, framework try-in, try-in evaluation, insertion, occlusal equilibration, and follow-up care and adjustments for 6 months following insertion.

Remake, partial denture. You are only covered when a replacement partial denture would be covered.

Denture adjustments This procedure includes 6 month follow-up care.

Tissue conditioning You are covered for this procedure.

Fixed bridges The alternate benefit clause, outlined under *General description of the coverage*, may be applied. We will only pay for the least expensive alternate procedure when considering the cost of a bridge.

- initial bridges. Limited to teeth extracted while you are covered under this plan.
- replacement bridges.
  - limited to teeth extracted while you are covered under this plan until you have been covered for 12 consecutive months.
  - after you have been covered for 12 consecutive months, replacement bridges are covered provided the existing bridges are at least 10 years old.

This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, splinting and intraoral indexing for soldering purposes, insertion, occlusal adjustments, and cementation. Does not include porcelain or porcelain fused to metal abutments or pontics for molar teeth.

You are also covered for the following procedures:

- repairing fixed bridges.
- recementing fixed bridges.

TMJ treatment

The hinge joint of the jaw is called the temporomandibular joint or TMJ. You are covered for TMJ appliances, including a maximum of 2 TMJ x-rays in any 12 month period. You are not covered for appliances for tooth movement or tooth guidance.

Miscellaneous

- diagnostic casts – unmounted for prosthetic dentistry. You are covered for 1 diagnostic cast every 36 months.
- retentive pins with inlays, onlays or crowns. This procedure is for the retention and preservation of the tooth. You are covered for 3 pins per tooth.
- retentive pins with fixed bridges. This procedure is for the retention and preservation of the tooth. You are covered for 3 pins per tooth.
- cast metal post and core – custom made casting includes cast core. This procedure is for teeth which have had root canal therapy. You are covered for 1 post and core per tooth.
- prefabricated post, prefabricated post and core – manufactured metal post – manufactured metal post and core. This procedure is for teeth which have had root canal therapy. You are covered for 1 post and core per tooth.
- amalgam and pin crown build-up, composite and pin crown build-up. This procedure is for the retention and preservation of the tooth.
- repair of inlays, onlays or crowns.
- recement inlays, onlays or crowns. You are covered for 1 unit of 15 minutes per tooth every 6 months.

Orthodontic procedures

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

Only children under age 19 are covered for these procedures.

We will pay 50% of the eligible expenses for these procedures.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- orthodontic examination. This procedure includes diagnostic casts, complete radiograph series or panoramic film, cephalograms, facial and intraoral photographs, consultations and case presentation.
- surgical exposure of impacted tooth. This procedure is covered for orthodontic purposes.
- fixed or removable orthodontic appliances. This procedure includes tooth movement or tooth guidance.
- orthodontic band splint.

When coverage ends

Dental Care coverage will end when the employee retires or reaches age 70, whichever is earlier.

Coverage may also end on an earlier date, as specified in *General Information*.

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 only pay for a procedure that has a reasonably favourable prognosis in the opinion of Sun Life.

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).
- charges related to the temporomandibular joint (TMJ) treatment, except otherwise indicated in the list of covered expenses.
- 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 or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca. The dentist will have to complete a section of the form.

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

- 365 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.

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

Long-Term Disability

General description of the coverage

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

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

For your Long-Term Disability coverage,

- during the elimination period and the following 24 months (this period is known as the **own occupation period**), you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

If you have 35 or more years of employment with your employer, you will be considered totally disabled while you are prevented by illness from performing the essential duties of your own occupation.

If you must hold a government permit or licence to perform your own occupation and your permit or licence is withdrawn or not renewed solely for medical reasons, we will consider you totally disabled for up to 12 months after the end of the elimination period. You cannot be working other than in a Sun Life approved partial disability or rehabilitation program.

Benefits are paid at the end of each month and are based on your coverage on the date you became totally disabled.

If benefits are payable for part of any month, we will pay 1/30 of the monthly benefit for each day for which you are entitled to a benefit payment.

Proof of good health

Proof of good health is required for coverage in excess of $4,500, and any increase in that coverage of 25% or more or $500, whichever is greater. Coverage will not take effect before Sun Life approves the proof of good health. There may also be other cases when you will be required to provide proof of good health; please contact your employer for additional information as it may impact the amount of your coverage.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 4 months or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 4 months and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

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 66.67% of your monthly basic earnings up to a maximum of $7,500. For coverage in excess of the amount indicated under *Proof of good health*, your coverage is subject to approval by Sun Life. Refer to *Proof of good health* above for further information.

Step 2: We subtract any benefits or payments provided to you:

- for the same or a subsequent disability under any government-sponsored plan, such as the Canada Pension Plan and the Québec Pension Plan excluding all benefits or payments on behalf of a dependent, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.

- under a motor vehicle insurance plan which provides disability benefits or payments to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind but excluding any benefits or payments provided under a Critical Illness plan.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under the Québec Parental Insurance Plan.

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

If this amount plus the above sources of benefits and payments and all the additional sources of benefits and payments listed below exceeds 85% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 80% of your pre-disability basic earnings after income tax.

Additional sources of benefits and payments are those provided:

- under any Workers' Compensation Act or similar law for another disability, excluding any automatic cost-of-living increases that occur after benefits begin.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.

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.

Maternity / parental leave of absence

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 4 months, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

Partial disability program

You may be required to participate in a partial disability program approved by Sun Life in writing.

After you are eligible for Long-Term Disability payments, you may be considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

During your partial disability program, you can receive a salary from your employer for the hours worked. However, your Long-Term Disability payments will be reduced by the percentage of your normal work week that you are now working for your employer.

During your partial disability program, the total of any income, benefits and payments provided from all sources cannot exceed 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable). If this is the case, your Long-Term Disability payments will be further reduced by the excess.

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

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

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

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your 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 pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long-Term Disability payments will be reduced by the excess.

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

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and all of the following conditions are met:

- the initial period of total disability lasts for at least 30 days without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the elimination period.

If the Long-Term Disability benefit terminates, any balance of the elimination period must subsequently be completed by uninterrupted total disability.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again 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. You must be covered when total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability.

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.

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. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust until it is paid to us.

We have the right to withhold or discontinue disability payments if you refuse or fail to comply with any of these terms.

Your responsibilities

During your total disability, you must make reasonable efforts to:

- 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.
- obtain training in order 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 obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

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 last day of the month in which you reach age 65.
- 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.

Survivor Benefit

If you die while you are receiving Long-Term Disability payments, Sun Life will pay 3 times your last monthly payment to your spouse, dependent children or your estate. Sun Life will make this payment to your spouse, if living. If your spouse is deceased, Sun Life will make this payment to your dependent children, in equal shares. If there are no dependents, Sun Life will make this payment to your estate.

When coverage ends

Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 4 months or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

If the Long-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- 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 except as stated under *Maternity / parental leave of absence* or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if:

- you have been covered for Long-Term Disability with your employer for at least 13 weeks during which you have been actively working continuously (up to 3 days of absence does not count) and you have not been treated by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- you became totally disabled more than 12 months after your coverage began.

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.

When and how to make a claim

In order to avoid delays in processing, we encourage you to submit your claim 8 weeks prior to the completion of your elimination period.

To make a claim, claim forms that are available from your employer must be completed. You, the attending doctor and your employer will have to complete claim forms.

In order to receive benefits, we must receive these forms no later than 90 days after the end of the elimination period. In any event, we must receive notice of claim within 30 days of the termination of this Long-Term Disability benefit.

We will assess the claim and send you or your employer a letter outlining our decision.

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 this request, you will not be entitled to benefits.

Critical Illness

General description of the coverage

Critical Illness coverage provides a benefit if, after the effective date of coverage, and while coverage is in force, you have a diagnosis of a covered condition, or you have surgery for a covered condition, as indicated below under *What we will pay*.

To qualify for this coverage you must be a resident of Canada.

Critical Illness coverage for you

Coverage

The amount of coverage is $10,000.

Coverage ends

Your coverage will end when you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information.*

In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.

What we will pay

We will pay the Critical Illness benefit if, after the effective date of coverage, and while coverage is in force, you have a diagnosis of a covered condition, or you have surgery for a covered condition, subject to the survival period. Claims will be assessed based on the Critical Illness provisions in effect on the date of diagnosis or surgery.

The Critical Illness benefit is payable only on the first covered condition for which a diagnosis is effective, or surgery is performed, and the person's coverage then terminates. Such person may not become covered again under this benefit.

We reserve the right to require examination of the covered person and confirmation of any diagnosis of or surgery for any covered condition, by a medical practitioner appointed by us in order for any Critical Illness benefit to become payable.

Diagnosis Diagnosis means a written diagnosis by a physician or specialist physician, licensed and practicing in Canada, of the covered condition. Any diagnosis must be made while coverage is in force and will be effective as of the date it is established by the physician or specialist physician, as supported by the covered person's medical records. Any diagnosis of a covered condition that was made prior to the effective date of coverage will not be covered.

Life Support Life support means the covered person is under the regular care of a licensed physician or specialist physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Physician Physician means a legally and professionally qualified medical practitioner practicing in Canada. The physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Specialist physician Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a speciality examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Surgery Surgery means a medical operation performed on the covered person and recommended by a physician or specialist physician, licensed and practicing in Canada.

Survival period Survival period means the period starting on the date of diagnosis of the critical condition and ending 30 days following the date of diagnosis of the critical condition, unless a covered condition described below expressly modifies this definition. The survival period does not include the number of days on life support. The covered person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.

Who we will pay

The Critical Illness benefit is payable to you or, in the event of your death, to your estate.

Changes in coverage

Changes in the amount of coverage or covered conditions may occur as the result of an employment status change or a change in plan design.

Changes in the amount of coverage

If you are not actively working on the date a change occurs, refer to *Changes affecting your coverage* in the *General Information* section to understand the effective date of any change to the amount of Critical Illness coverage.

The *Pre-existing conditions* provision under *What is not covered* will apply to increased amounts of coverage as described in that provision.

Other changes

If new Critical Illness conditions are added to this plan, the new Critical Illness conditions will only apply to :

- employees who are actively working; and
- employees already having Critical Illness coverage

on the date that the change occurs. The effective date of coverage for the new covered conditions is the date of the change to the plan.

If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions.

In all instances, we will :

- apply the effective date of coverage to determine your eligibility for a Critical Illness benefit payment; and
- apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where proof of good health was previously required for your coverage.

If the definition of a Critical Illness condition is changed, we will adjudicate any claim for a Critical Illness benefit based on the definition of that Critical Illness condition in effect on the date of the diagnosis or surgery, regardless of whether you were actively working on the date of the change.

In the event of a change of carrier, the following rules apply to any employee who was covered under the previous group contract on the date immediately preceding the effective date of coverage under this plan:

- the new plan, including coverage for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all employees on the effective date of this plan, regardless of whether the employee is actively working on such date;
- for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of coverage is the effective date of this plan; and
- for Critical Illness conditions under this plan which were also covered under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of coverage is the date the employee most recently became covered under the previous carrier's plan.

If an employee received a Critical Illness benefit payment under the previous carrier's plan, then such employee will not be covered under this plan for that Critical Illness condition for which a benefit payment was already made.

Sun Life is not responsible for any claim where the date of diagnosis or surgery, as applicable, is before the effective date of this plan.

Aortic Surgery

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia

Aplastic Anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Bacterial Meningitis

Bacterial Meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

Exclusion:

No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour

Benign Brain Tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

The diagnosis of benign brain tumour must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date a person enrols for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour (covered or excluded under this coverage),

no benefit will be payable for benign brain tumour for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for benign brain tumour for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

Blindness

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Cancer (Life-threatening)

Cancer (Life-threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of cancer must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

No benefit will be payable under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date a person enrols for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; or

- a diagnosis of cancer (covered or excluded under this coverage),

no benefit will be payable for cancer for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for cancer for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

For the purposes of this benefit, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For the purposes of this benefit, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Coma

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

The diagnosis of coma must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

- a medically induced coma;
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

Coronary Artery Bypass Surgery

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of deafness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Dementia, including Alzheimer's Disease

Dementia, including Alzheimer's Disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour), which is affecting daily life.

The covered person must exhibit:

dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and

evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusion:

No benefit will be payable under this condition for affective or schizophrenic disorders or delirium.

For purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack

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

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

The diagnosis of heart attack must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart Valve Replacement or Repair

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure

Kidney Failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The diagnosis of kidney failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Independent Existence

Loss of Independent Existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs

Loss of Limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The diagnosis of loss of limbs must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Speech

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

The diagnosis of loss of speech must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Exclusion:

No benefit will be payable under this condition for any psychiatric related causes.

Major Organ Failure on Waiting List

Major Organ Failure on Waiting List means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the covered person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

For the purposes of the survival period, the date of diagnosis is the date of the covered person's enrolment in the transplant centre.

The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Major Organ Transplant

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

The diagnosis of major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of their transplant.

Motor Neuron Disease

Motor Neuron Disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Multiple Sclerosis

Multiple Sclerosis means a definite diagnosis of at least one of the following:

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

The diagnosis of multiple sclerosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Occupational HIV Infection

Occupational HIV Infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the covered person's normal occupation, which exposed the person to HIV contaminated body fluids.

For any amount of coverage, the accidental injury leading to the infection must have occurred after the later of:

- the date a person enrols for any amount of coverage; or
- the effective date of such amount of coverage.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying this requirement.

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

- the accidental injury must be reported to Sun Life within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist physician. The covered person must survive for 30 days following the date of the second serum HIV test described above.

Exclusions:

No benefit will be payable under this condition if:

- the covered person has elected not to take any available licensed vaccine offering protection against HIV;
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of paralysis must be made by a specialist physician. The covered person must survive for 90 days following the precipitating event.

Parkinson's Disease

Parkinson's Disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The covered person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist or a specialist physician. The covered person must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date a person enrols for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage),

no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for those additional amounts. All other coverage remains in force.

No benefit will be payable under Parkinson's disease and specified atypical parkinsonian disorders for any other type of parkinsonism.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

Severe Burns

Severe Burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

The diagnosis of severe burns must be made by a specialist physician. The covered person must survive for 30 days following the date the severe burn occurred.

Stroke (Cerebrovascular Accident)

Stroke (Cerebrovascular Accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma; or

- lacunar infarcts which do not meet the definition of stroke as described above.

What is not covered

We will not pay for any illness, disorder or surgery not specifically defined under *Covered conditions*.

No benefits are payable for claims resulting directly or indirectly from any of the following:

- intentionally self-inflicted injuries or attempted suicide, while sane or insane.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol.

No cancer coverage of any type is provided if a diagnosis of cancer is made, or any symptom or medical problem which initiated the investigation leading to a diagnosis of cancer commenced within 90 days following the effective date of the covered person's coverage under this benefit. However, coverage under all other covered conditions continues in force.

Pre-existing conditions

For any amount of coverage that:

- did not require proof of good health; and
- has been in effect for less than 12 months under the employer's Critical Illness plan,

no benefits are payable for any covered condition that results from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person, during the 12 months prior to the effective date of such amount of coverage:

- had signs, symptoms, consulted a physician or other health care practitioner; or
- was provided any health-related care, advice or treatment; or

- would have consulted a physician or other health care practitioner, acting as a reasonably prudent person with such injury, sickness, medical condition, signs or symptoms.

If coverage ends but the person is covered again under this benefit, we will use the latest date the person's coverage began when applying the above limitation.

Portability

If your Critical Illness coverage ends for any reason other than your request, you may apply to transfer the group Critical Illness coverage to another critical illness policy without providing proof of good health.

The request must be made within 60 days of the end of the Critical Illness coverage.

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

When and how to make a claim

We must receive notice of claim as soon as reasonably possible after the date of diagnosis or surgery. We will provide the claimant with the appropriate claim forms on receipt of notice. Initial notice must be received no later than 30 days and proof of claim no later than 90 days from the date of diagnosis or surgery.

Failure to give notice of claim or furnish proof of claim within the above time limits does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to give notice or furnish proof within the above time limits.

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.

There are cases when you will be required to provide proof of good health when you request coverage for yourself or your dependents, or an increase in coverage. Contact your employer to know when this is necessary as it may impact the amount of your coverage.

Life coverage for you

Amount Your Life benefit is $50,000.

Reduction Your benefit will reduce to 50% of the above amount when you reach age 65.

If you continue, or begin, to work after having reached age 65, we calculate the amount for which you would have been eligible if you had not already reached age 65, then, we apply the above reduction clause to calculate the amount for which you are eligible.

Coverage ends Your coverage will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Life coverage for your dependents

Amount Your spouse's benefit is $5,000. Your children's benefit is $2,500 per child.

Coverage ends Coverage for your dependents will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

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 or if the beneficiary has died, 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.

If a dependent dies, Sun Life will pay you the benefit for that dependent.

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.

Coverage during total disability

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage for you and your dependents 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. In addition, this continued coverage for your dependents terminates on the date the benefit under which the dependent is covered terminates.

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:

- an uninterrupted period of 6 months, or
- the elimination period for Long-Term Disability if you are entitled to Long-Term Disability payments, whichever is shorter.

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. However, if you are totally disabled under the Long-Term Disability benefit, you are also considered to be totally disabled under the Life benefit.

Retirement Date

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

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.

If your spouse's Life coverage ends for any reason other than your request, 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 due to the termination of your Life coverage, 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 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.

Accidental coverage for you

Amount The amount of your Accidental Death and Dismemberment coverage is equal to the amount of your Life coverage.

Coverage ends Your coverage will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

What we will pay

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, your 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 an aircraft, descending from an aircraft 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. The amount of this Accidental Death benefit cannot be more than the amount of Life coverage you are converting.

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.

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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).

www.sunlife.ca

Printed in Canada
942-2515 (08-02)