



Sun
Life Financial

your **group**
benefits



West Coast Medical Imaging Inc.

Union employees

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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 105765 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.
- you are actively working for your employer at least 24 hours a week.
- you have completed the waiting period.

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

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-

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

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada or the United States.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last year, 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 22.

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

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

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

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

information about this.

Enrolment

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to 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 group 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.

When coverage begins

Your coverage begins on the date you become eligible for coverage.

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

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

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

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

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

Changes affecting your coverage

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

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

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

in coverage:

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- change of dependents.
- change of name.
- change of beneficiary.

Accessing your records

As required by legislation, for insured benefits, if you reside in Alberta or British Columbia, you may obtain copies of the following documents:

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

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

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

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

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

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

- the date your employment ends or you retire.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

A dependent's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

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

However, if you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following dates:

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

terminates.

Replacement coverage

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association 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 an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. 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

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different

limitation period, no legal action or proceeding may be brought against Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for disability benefits that have been paid by Sun Life for some period of time, more than one year after the last date for which disability benefits have been paid, or
- regarding all other claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim, or
- regarding claims for *Coverage during total disability* which are initially approved, more than one year after the date you cease to be covered or your premiums cease to be waived.

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

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

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.

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

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

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

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

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

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.

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.

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

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

Extended Health Care (Medicare Supplement)

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *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.

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 February 3, 2014 to December 31, 2014, and then from January 1 to December 31.

Deductible The deductible is the portion of claims that you are responsible for paying.

For prescription drugs the deductible is equal to the dispensing fee for each prescription or refill.

For other expenses, there is no deductible.

Benefit year maximum Under Extended Health Care, for prescription drugs we will not pay more than \$5,000 per member and family combined, per benefit year.

Prescription drugs After you pay the deductible, we will cover the 100% of cost of the following drugs and supplies that are prescribed by a doctor or dentist

and are obtained from a pharmacist:

- selected drugs with a Drug Identification Number (DIN) and supplies that are therapeutically useful and cost effective, and listed in the British Columbia drug benefit plan.
- selected natural health products with a Natural Product Number (NPN), where provided in the provincial drug benefit plan.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

After you pay the deductible, we will also cover 50 % the cost of drugs for the treatment of infertility, up to a lifetime maximum of \$1,000 for each person.

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.

***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 covered for these drugs if the information you and your doctor provide meets our medical criteria. 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

*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.

We will also cover 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 \$25 per day for treatment of an illness due to the same or related causes.

For purposes of this plan, 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.

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.

Chronic care hospital

We will cover 100% of the cost of room and board in a chronic care hospital.

The maximum amount payable is \$25 per person per day.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. 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.

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, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ 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 Europ Assistance cannot be made before services are provided, contact with Europ 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 Europ 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 100% 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 can not perform the duties. There is a limit of \$5,000 in any 12 month period for each illness due to the same or related causes.
- 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 \$1,000 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 \$50 per person in any 12 month period for a person under age 18 or in any 24 month period for any other person.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- wigs following chemotherapy, up to a lifetime maximum of \$200 per person. 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 4 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a combined maximum of \$300 per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$500 per person over a period of 4 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a maximum of \$150 per person over a period of 4 benefit years.
- insulin pumps.

**Paramedical
services**

We will cover 100% 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, when ordered by a doctor.
- licensed speech therapists, when ordered by a doctor.
- licensed physiotherapists.

- licensed naturopaths.
- 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.

**Contact lenses,
eyeglasses or laser
eye correction
surgery**

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 \$200 per person in any 24 month period.

We will also cover 100% of the costs of contact lenses prescribed for the treatment of severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, if visual acuity in the better eye cannot be improved to at least 20/40 with eyeglasses, up to a lifetime maximum of \$200.

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.

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

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

Emergency Travel Assistance

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (*Europ 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 Europ Assistance. If contact with Europ Assistance cannot be made before services are provided, contact with Europ 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.

Europ Assistance may arrange for:

On the spot medical assistance

Europ Assistance will provide referrals to physicians, pharmacists and medical facilities.

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ 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, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Europ Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel.

Europ Assistance will transmit an urgent message from you to your home, business or other location. Europ Assistance will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Europ 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, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Europ 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, Europ 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.

Europ 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 Europ 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

Europ 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, Europ 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

Europ 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, Europ 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

Europ 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, Europ 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 Europ Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Europ 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 Europ 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 Europ 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 Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.

Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

- a rebellion, riot, military up-rising, war, labour disturbance, strike,

nuclear accident or an act of God.

- the refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

**Liability of Sun Life
or Europ Assistance**

Neither Sun Life nor Europ 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 expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

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

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

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable 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.

The benefit year is from February 3, 2014 to December 31, 2014, and then from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than \$1,500 per person for the first benefit year, and \$1,500 per person for each following benefit 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

1 complete examination every 3 benefit years.

1 recall examination every 12 months.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 3 benefit years, includes introral periapical x-rays.

1 set of bitewing x-rays every 12 months.

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

Other services

Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 12 months.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 12 months.

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 Amalgam, composite, acrylic or equivalent.

Extraction of teeth Removal of teeth, except removal of impacted teeth (*Preventive dental procedures*).

Basic restorations Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.

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

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

For scaling, you are covered up to a maximum of 6 units of 15 minutes every 9 months.

For occlusal equilibration, you are covered up to a maximum of 4 units of 15 minutes per benefit year.

Oral surgery Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).

Repair Repair of dentures.

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

Major dental procedures

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

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

Major restorations Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).

Repair Repair of bridges.

Remake Remake of dentures, once every 36 months.

Prosthodontics

Construction and insertion of bridges or standard dentures, after the person has been covered continuously under this provision for a period of 12 months. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

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

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

We will not pay for:

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

- experimental treatments.
- charges related to implants, including surgery charges.

We will also not pay for dental work resulting from:

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

**When and how to
make a claim**

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

In order for you to receive benefits, we must receive a claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your Dental Care coverage.

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.

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.

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

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 119 days 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 119 days 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 income in this disability provision are to the gross amounts before any deductions.

Step 1: We take 66.7% of the first \$2,250 of your monthly basic earnings, add 50% of the next \$3,500 and then add 40% of the balance of your monthly earnings, if any, up to a maximum benefit of \$5,000.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, 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 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.
- 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 income and all the additional sources of income 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 85% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

- 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 income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above 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 that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

We have the right to adjust your benefit payments when necessary.

**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 119 days, 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 your total income 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 from other sources. However, if during any month your total income 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.

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

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

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 income 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 for us.

We have the right to withhold or discontinue disability income 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.

- When coverage ends** Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 119 days 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 consider you totally disabled if your disability results from drug or alcohol abuse. However, this limitation will not apply while you are participating in a Sun Life approved treatment program or you have an organic disease which would cause total disability even if drug and alcohol abuse ended.

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 or attempted suicide, while sane or insane.
- participation in a criminal offence.

When and how to make a claim

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

We must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins,
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give us as many details about the claim as possible. You, the attending doctor and your employer will all 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.

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, a diagnosis is made that you have experienced a covered condition, or have had 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, a diagnosis is made that you have experienced a covered condition, or have had surgery for a covered condition, subject to the survival period.

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 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.

Covered conditions

We provide coverage for any illness, disorder or surgery that is defined below:

Cancer

Cancer means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

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 non-life threatening cancers:

- carcinoma in situ; or,
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion); or,
- any non-melanoma skin cancer that has not become metastasized; or,
- Stage A (T1a or T1b) prostate cancer.

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; or,
- 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:

Heart attack does not include:

- 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.

*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; and,

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; or,
- 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.

Pre-existing conditions

For any coverage that did not require proof of good health, no benefits are payable for any covered condition that occurs within 12 months of the effective date of the covered person's coverage, and that resulted from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person had symptoms, consulted a physician or other health care practitioner or was provided any health-related care, advice or treatment, or that a reasonably prudent person with such injury, sickness or medical condition would have consulted a physician or any other health care practitioner, during the 12 months prior to the effective date of the covered person's coverage. 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 a group critical illness policy set up for that purpose by Sun Life without providing proof of good health.

The request must be made within 31 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.

Best Doctors

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

If you are covered for Critical Illness, you, your spouse and your children have access to Best Doctors.

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition, even if it is not a covered condition under this Critical Illness benefit. To use this service, please call Best Doctors at 1-877-419-BEST (2378).

**Liability and
responsibility of
Sun Life**

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

Sun Life cannot guarantee the availability of Best Doctors services.

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.

Life coverage for you

Amount Your Life benefit is 2 times your annual basic earnings, rounded to the next higher \$1,000. The maximum amount of coverage is \$500,000.

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

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 \$10,000. Your children's benefit is \$5,000 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, 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 may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

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

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

Total disability must continue for:

- 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.

Dependent Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Dependent Life benefit is terminated.

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.

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 Your Accidental Death and Dismemberment coverage is 2.5 times your annual basic earnings, rounded to the next higher \$1,000. The maximum amount of coverage is \$500,000. The minimum amount of coverage is \$20,000.

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

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, this Accidental Death and Dismemberment coverage will continue without the payment of premiums, for as long as premiums are not payable for your Life coverage, but not beyond age 65 or termination of the Accidental Death and Dismemberment benefit.

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 while sane or insane.
- flying in, descending from or being exposed to any hazard related

to an aircraft while

- receiving flying lessons.
 - performing any duties in connection with the aircraft.
 - being flown for a parachute jump.
 - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
 - full-time service in the armed forces of any country.
 - participation in a criminal offence.

Converting coverage If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy. 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

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

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).

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or to obtain information about our privacy practices, send a written request by e-mail to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

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