Sun Life Financial

your group benefits

INTRAWEST

Intrawest ULC

National Executive Group,
Core and Regular Full-time employees,
Seasonal employees, Guides, Full-time contract employees,
Salaried employees, Regular employees,
Canadian Mountain Holidays LP – Non-Residents,
Ski Butlers Tremblant, Ski Butlers Blue Mountain
and employees on leave

Contract Number 101258, 150258, 100005332, 100005333
Effective September 1, 2025

The Basic A.D.& D. Insurance and Voluntary A.D.& D. Insurance benefits are insured by Industrial-Alliance Insurance and Financial Services Inc.

Table of Contents

Benefit Details **5**

General Information **15**
Classes 15
About this booklet 17
Eligibility 17
Who qualifies as your dependent 20
Enrolment 21
When coverage begins 21
Changes in options 22
Changes affecting your coverage 23
Updating your records 24
Accessing your records 24
When coverage ends 24
Replacement coverage 26
Making claims 26
Legal actions for insured benefits 26
Legal actions for self-insured benefits 27
Proof of disability 27
Coordination of benefits 27
Medical examination 29
Recovering overpayments 29
Definitions 29

Extended Health Care **33**
Plan administrator 33
General description of the coverage 33
Benefit year 33
Prescription drugs 34
Hospital expenses in your province 39
Expenses out of your province but within Canada for Classes LCM, LMW, GOL and WOL 40
Expenses out of your province for all other Classes 43
Medical services and equipment 46
Paramedical services 49
Vision care 49
Payments after coverage ends 49
What is not covered 50

Integration with government programs 51
When and how to make a claim 51

Emergency Travel Assistance (Medi-Passport) 52
Plan administrator 52
General description of the coverage 52

Dental Care 58
Plan administrator 58
General description of the coverage 58
Benefit year 59
Reimbursement level 59
Benefit year maximum 59
Lifetime maximum 60
Predetermination 60
Preventive dental procedures 60
Basic dental procedures 61
Major dental procedures 62
Orthodontic procedures 62
Payments after coverage ends 63
What is not covered 63
When and how to make a claim 64

Health Spending Account 65
Plan administrator 65
General description of the coverage 65
Benefit year 65
How your Health Spending Account works 65
Continuation of coverage for dependents 66
Plan credits 66
Eligible expenses 66
Other coverage 72
When and how to make a claim 72

Short-Term Disability 73
Insurer 73
General description of the coverage 73
When disability payments begin 73
Interrupted periods of disability 74
What we will pay 74
Maternity / parental leave of absence 77
If you recover damages from another person 78
When payments end 78

Payments after coverage ends 79
What is not covered 79
When and how to make a claim 80

Long-Term Disability 81
Insurer 81
General description of the coverage 81
When disability payments begin 82
What we will pay 82
Maternity / parental leave of absence 84
Partial disability program 85
Rehabilitation program 86
Interrupted periods of disability during elimination period 86
Interrupted periods of disability after payments begin 87
If you recover damages from another person 87
Your responsibilities 88
When payments end 88
Survivor Benefit 89
Payments after coverage ends 89
What is not covered 89
When and how to make a claim 90

Critical Illness 92
Insurer 92
General description of the coverage 92
Critical Illness coverage for you 92
Critical Illness coverage for your spouse 92
What we will pay 92
Who we will pay 94
Changes in coverage 94
Covered conditions 96
What is not covered 111
Portability 112
When and how to make a claim 113
Sun Life Medical Second Opinion, by Dialogue* 113
Exclusion of liability 113

Life Coverage 114
Insurer 114
General description of the coverage 114
Who we will pay 114
Suicide 115
Coverage during total disability 115

Converting Life coverage....116
When and how to make a claim....116

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLASS 1....117

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLASS 2....123

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE....129

Benefit Details

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

Your Extended Health Care options

	Opt Out	Bronze	Silver	Gold
Benefit year	January 1 to December 31			
Prescription drug deductible	N/A	Individual – $900 per benefit year Family – $900 per benefit year	Individual – $11 for each prescription or refill Family – $11 for each prescription or refill	Individual – $11 for each prescription or refill Family – $11 for each prescription or refill
Prescription drug	N/A	100% Drug card plan Mandatory substitution limit	80% Drug card plan Mandatory substitution limit	100% Drug card plan Mandatory substitution limit
	For Bronze, Silver and Gold options, we will cover 100% of the cost of the following drugs without a deductible: ▪ vaccines, up to a maximum of $400 per person in a benefit year ▪ products to help you quit smoking, up to a lifetime maximum of $350 per person			
	For Silver option: For employees residing in Québec, the reimbursement percentage is increased to 100% for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached. However, if the drug submitted for reimbursement has a lower priced equivalent drug, only the cost of the lowest priced equivalent drug will be considered at 100%, unless Sun Life specifically approved the cost of the higher priced drug.			
	Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet the requirements			
Hospital expenses in your province	NA	Not covered	80% semi-private room	100% private room

Your Extended Health Care options

	Opt Out	Bronze	Silver	Gold
Convalescent hospital Maximum	NA	Not covered	80% Maximum 120 days	100% Maximum 120 days
Expenses out of your province	Emergency – 100% Referral – 100%			
Medi-Passport (not applicable to Classes LCM, LMW, GOL, WOL)	NA	Covered	Covered	Covered
Medical services and equipment	NA	Not covered	80%	100%
Private duty nursing*	For Bronze, Silver and Gold options, we will cover 100% of the cost for private duty nursing without a deductible, up to a maximum of 720 hours per person per benefit year			
Accidental dental expenses *	For Bronze, Silver and Gold options, we will cover 100% of the cost for dental services without a deductible, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered, up to a maximum of $5,000 per person per accident.			
Diagnostic services (ultrasounds & MRI etc.) Max. per benefit year	NA	Not covered	80% combined maximum of $1,000 per person	100% combined maximum of $1,000 per person
(laboratory tests) Max. per benefit year *	For Bronze, Silver and Gold options, we will cover 100% of the cost for laboratory tests without a deductible, including x-ray examinations performed by licensed osteopaths, podiatrists or chiropodists, up to a combined maximum of $500 per person in a benefit year.			
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	N/A	Not covered	80% $150 per benefit year for a person under age 21 $300 per benefit year for any other person	100% $300 per benefit year for a person under age 21 $600 per benefit year for any other person

Your Extended Health Care options

	Opt Out	Bronze	Silver	Gold
Paramedical services			80%	100%
Max. per category of specialists	N/A	Not covered	Up to a combined maximum of $1,000 per person per benefit year for all paramedical services listed below:	Up to a combined maximum of $1,000 per person per benefit year for all paramedical services listed below:
			■ licensed psychologists or social workers. ■ clinical counsellors who are active members of a provincial association which is approved by Sun Life. ■ licensed psychotherapists, or psychotherapists who are active members of a provincial association approved by Sun Life. ■ licensed psychiatrists.	
			Up to a combined maximum of $1,000 per person per benefit year for all paramedical services listed below:	Up to a combined maximum of $1,500 per person per benefit year for all paramedical services listed below:

Your Extended Health Care options

Opt Out	Bronze	Silver	Gold
		■ licensed massage therapists. ■ licensed speech therapists. ■ licensed physiotherapists. ■ licensed naturopaths. ■ licensed acupuncturists. ■ licensed audiologists. ■ licensed dieticians. ■ licensed occupational therapists. ■ licensed osteopaths or osteopathic practitioners. ■ licensed chiropractors. ■ licensed podiatrists or chiropodists. ■ licensed athletic therapists, or athletic therapists who are active members of the Canadian Athletic Association (CATA) or of a provincial association approved by Sun Life.	

Your Extended Health Care options

	Opt Out	Bronze	Silver	Gold
Vision care	N/A	Not covered	Contact lenses, eyeglasses or laser eye correction surgery – 80%, up to a maximum of $200 in any 12 month period for a person under age 19 or in any 24 month period for any other person Services of an ophthalmologist or licensed optometrist – 80%, up to a maximum of 1 examination in any 12 month period for a person under age 19 or in any 24 month period for any other person	Contact lenses, eyeglasses or laser eye correction surgery – 100%, up to a maximum of $300 in any 12 month period for a person under age 19 or in any 24 month period for any other person Services of an ophthalmologist or licensed optometrist – 100%, up to a maximum of 1 examination in any 12 month period for a person under age 19 or in any 24 month period for any other person
Overall maximum	Expenses incurred for referred services outside Canada – lifetime maximum of $1,000,000 per person All other expenses – none			
Changes in options	You can change your option during the annual enrolment period. You can change your option within 31 days of a *life event change*. Proof of good health is not required.			
Coverage ends	When the employee retires. Coverage may also end on an earlier date, as specified in *General Information*.			

Your Dental Care options

	Opt Out	Bronze	Silver	Gold
Benefit year	January 1 to December 31			
Deductible	N/A	Individual – $200 per benefit year Family – $200 per benefit year deductible does not apply to Preventive services	None	None
Reimbursement Level	N/A	N/A	As described below	As described below
Preventive	N/A	75%	80%	90%
Basic	N/A	75%	80%	90%
Major	N/A	75%	50%	60%
Orthodontics	N/A	Not covered	50%	60%
Benefit year maximum	N/A	$1,000 per person*	$2,000 per person*	$3,000 per person*
	*Orthodontic procedures are not included in the benefit year maximum. A separate lifetime maximum applies.			
Lifetime maximum (per person)	N/A	N/A	$2,000 for Orthodontics	$5,000 for Orthodontics
Fee guide	The current fee guide for general practitioners approved by the Dental Association in the province where the treatment is received			
Changes in options	You can change your option during the annual enrolment period. You can change your option within 31 days of a *life event change*. Proof of good health is not required.			
Coverage ends	When the employee retires. Coverage may also end on an earlier date, as specified in *General Information*.			

Your Health Spending Account

This benefit is not applicable to Classes GOL and WOL

Benefit year	January 1 to December 31
Plan credits	Flex credits allocated by you on the first day of each month of the benefit year as outlined by the Contract Holder.
Coverage ends	When the employee retires.

Your Short-Term Disability coverage

This benefit is not applicable to Classes GUI, LSR, LCM, LMW, NEB, NES, RGC, RGM, RGK, SEB, SLC, SLM, GOL, WOL, SLK and MWG

Coverage	60% of your weekly basic earnings
Maximum	$1,000
Coverage ends	When you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Your Long-Term Disability coverage

This benefit is not applicable to Classes CTS, LSR, LCM, LMW, GUI, RGC, RGM, RGK, SEB, SLC, SLM, GOL, WOL, SLK and MWG

Coverage	60% of your monthly basic earnings
Maximum	$8,000
Own occupation period	The period during the elimination period and the following 24 months
Coverage ends	When you reach age 65, less the elimination period of 26 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Optional Critical Illness coverage

Coverage	As elected by the employee, units of $10,000
Maximum	$250,000
Proof of good health	Proof of good health will be required when you request optional coverage and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.
Coverage ends	When you retire or reach age 70, 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.

Optional Critical Illness coverage for your spouse

Coverage	As elected by the employee, units of $10,000
Maximum	$250,000
Proof of good health	Proof of good health for your spouse will be required when you request optional coverage for your spouse and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the spouse's proof of good health.
Coverage ends	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. In addition, your spouse's coverage will end on the date a Critical Illness benefit is paid for a covered condition which your spouse sustains.

Your Basic Life coverage

This benefit is not applicable to Classes GUI, GOL, WOL and MWG

Coverage	2 times your annual basic earnings rounded to the next higher $1,000
Minimum	$30,000
Maximum	$750,000
Proof of good health	Not required
Coverage reduces	50% of the above amount at age 65
Coverage ends	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Basic Life coverage

This benefit is applicable to Classes GUI, GOL, WOL and MWG only

Coverage	$75,000
Proof of good health	Not required
Coverage reduces	50% of the above amount at age 65
Coverage ends	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Optional Life coverage

Coverage	As elected by the employee, units of $25,000
Maximum	$500,000
Proof of good health	Required on all optional amounts
Coverage ends	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Coverage	As elected by the employee, units of $25,000
Maximum	$500,000
Proof of good health	Proof of good health of your spouse is required
Coverage ends	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your children

Coverage	As elected by the employee, units of $10,000
Maximum	$50,000
Proof of good health	Not required
Coverage ends	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

For Employee, Spouse and Child AD&D coverage information please refer to the AD&D section later in this booklet.

General Information

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

Classes

This booklet describes the coverage for the following classes of employees:

- Class NES – National Executive Group of Station Mont Tremblant Limited Partnership and Playground Real Estate Inc. - Tremblant
- Class CRC – CMH Salaried Employees
- Class CRS – Core and Regular Full-time employees and Seasonal employees of Mont Tremblant
- Class GUI – Guides
- Class GOL – CMH Guides on leave
- Class RGC – Regular employees of Canadian Mountain Holidays LP
- Class RGK – Regular employees of Canadian Mountain Holidays LP Kuskanax
- Class SLC – Seasonal employees of Canadian Mountain Holidays LP
- Class CTS – Full-time contract (12 months or greater) of Station Mont Tremblant Limited Partnership
- Class LCM – Canadian Mountain Holidays LP employees on leave

- Class LSR – Core, Regular and Seasonal employees on leave for Station Mont Tremblant Limited
- Class CRB – Core employees of Blue Mountain Resorts Ltd.
- Class SEB – Year round Seasonal employees of Blue Mountain Resorts Ltd.
- Class NEB – Executives of Blue Mountain Resorts Ltd.
- Class CSK – Kuskanax Salaried Employees
- Class SLK – Seasonal employees of Lodge at Arrow Lakes
- Class CFK – Fixed term employees of Kuskanax
- Class CFC – Fixed term employees of CMH
- Class CFT – Ski Butlers Tremblant
- Class CFB – Ski Butlers Blue Mountain
- Class MWS – Salaried employees – Mike Wiegele Helicopter Skiing
- Class MWG – Guides – Mike Wiegele Helicopter Skiing
- Class WOL – Guides on leave – Mike Wiegele Helicopter Skiing
- Class RGM – Regular employees – Mike Wiegele Helicopter Skiing
- Class SLM – Seasonal employees – Mike Wiegele Helicopter Skiing LP
- Class LMW – Employees on leave – Mike Wiegele Helicopter Skiing

- Class AMC – Regular employees of Alterra Mountain Company Employment

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 105548 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.

The contract holder, Intrawest ULC, self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Health Spending Account

This means, Intrawest ULC has the sole legal and financial liability for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.

Eligibility

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

- for Classes NES and NEB:
  - you are a permanent employee working in a Director level position or above.
  - you are actively working for your employer at least 30 hours a week.
  - you have completed the waiting period.
- for Classes RGC, RGM, RGK, CRC, CSK and MWS:
  - you are a permanent employee
  - you are actively working for your employer at least 20 hours a week.
  - you have completed the waiting period.
- for Classes CRS, CTS, CRB, CFT, CFB and AMC:
  - you are a permanent core employee, regular full-time employee or a full-time contract employee working a minimum 12 month term.
  - you are actively working for your employer at least 30 hours a week.
  - you have completed the waiting period.
- for Classes GUI, SLC, SLM, SLK and MWG:
  - you are a seasonal employee
  - you are actively working for your employer at least 20 hours a week.
  - you have completed the waiting period.
- for Class SEB:

- you are a seasonal employee
- you are actively working for your employer at least 30 hours a week.
- you have completed the waiting period.

- for Classes LSR, LCM, LMW, GOL and WOL:
  - you were covered under your employer's group plan on the day preceding your leave of absence or lay-off.

- for Classes CFK and CFC:
  - you are a fixed-term salaried employee
  - you are actively working for your employer at least 20 hours a week.
  - you have completed the waiting period.
  - your fixed-term salaried employment agreement is for a minimum of
    7 months.

The waiting period for your group plan is:

- for Classes NES, GOL, WOL, LSR, LCM, LMW and NEB: there is no waiting period for your group plan.
- for Classes CRS, CTS, CFT and AMC: 30 days following date of hire.
- for Classes CRB, SEB and CFB: 90 days following date of hire.
- for Classes CRC, CSK, RGC, RGM, RGK, CFK, CFC and MWS: 90 days of continuous employment.
- for Classes GUI, SLC, SLM, SLK and MWG: 160 working days 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. (For employees residing in Québec, there is no minimum cohabitation period if a child is born out of your relationship.) You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 19.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 25 (age 26 for Extended Health Care for employees residing in Québec) 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

To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer within 31 days after the date you become eligible. If your enrolment request is not received by your employer within the 31 day period, you will be covered for the ***Bronze*** coverage. You must elect the same option and the same family status for the Extended Health Care and Dental Care coverage. For a dependent to receive coverage, you must request dependent coverage.

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

For Optional Critical Illness coverage, proof of good health will be required as specified in the *Benefit Details* section. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.

When coverage begins

Your coverage begins on the later of the following dates:

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

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

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

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

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

For the Extended Health Care and Dental Care benefits, you must request coverage for any subsequent dependents.

For the Life coverage for your children, you must enrol each child during the first 31 days of the child's eligibility.

If you are not actively working on the date your spouse's Optional Life or Optional Critical Illness coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

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

Changes in options

You may change your options during the annual enrolment period or within 31 days of a *life event change*. Your request must be received by your employer during the annual enrolment period or within 31 days of the *life event change*. Refer to the *Benefit Details* section for information pertaining to changes in options.

Changes requested due to a *life event change*, will take effect on the later of the following dates:

- the date of the *life event change*.
- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.

Changes requested due to annual enrolment, will take effect on the later of the following dates:

- at January 1st.
- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.

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.

For a commissioned salesperson, any change in coverage resulting from a change in basic earnings will take effect on January 1st of each year.

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

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

When coverage ends

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

- the date your employment ends or you retire.
- the date you are no longer actively working.

- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.
- the date you leave on expatriate assignment to the United States.

If you leave on expatriate assignment to the United States, Optional Life coverage for yourself and your dependents can be continued, subject to the terms and conditions of the contract. You are allowed to request increases in coverage for yourself and your spouse at any time

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

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

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the *Benefit Details* section of this employee benefits booklet or contact your Benefit Administrator.

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

- 18 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.

The continuation of coverage does not apply to the spouse and child coverage under Optional Life and spouse coverage under Critical Illness.

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.

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

Making claims

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

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

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

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

Legal actions for insured benefits

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Legal actions for self-insured benefits

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

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

Definitions

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

Accident

An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.

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

For Classes CRB, NEB, NES, SEB and CFB: Basic earnings are the hourly base rate of pay for your occupation multiplied by 40 hours a week.

For Classes CRC, CSK, CFC, CFK and MWS: Basic earnings are the hourly base rate of pay for your occupation multiplied by 37.5 hours a week. Basic earnings will prorated for eligible employees who work fewer than 37.5 hours a week.

For Classes RGC and RGM: Basic earnings are the regular wages you received from your employer for the one-year period preceding the annual enrolment period. Basic earnings can be calculated on your day rate, or hourly wages, depending on your employee pay type. If employed less than one year, your actual earnings history will be annualized.

For Class RGK: Basic earnings are the regular wages you received from your employer for the one-year period preceding the annual enrolment period. Basic earnings can be calculated on your day rate, or hourly rate, depending on your employee pay type. If employed less than one year, your actual earnings history will be annualized.

For Classes GOL and WOL: Basic earnings on the day immediately preceding your leave start date. Basic earnings will be based on the regular wages you received from your employer in the one-year period preceding the annual enrolment period. Basic earnings can be calculated on your day rate, or hourly rate, depending on your employee pay type.

For Classes GUI and MWG: Basic earnings are the regular wages you received from your employer for the one-year period preceding the annual enrolment period. Basic earnings can be calculated on your day rate, or hourly wages, depending on your employee pay type.

For Classes SLC, SLK and SLM: Basic earnings are the regular wages you received from your employer for the one-year period preceding the annual enrolment period. Basic earnings can be calculated on your day rate, or hourly rate, depending on your employee pay type.

For Classes CRS, CFT and AMC: If you are a year-round full-time employee, basic earnings are the hourly base rate of pay for your occupation multiplied by your normal weekly work hours. If you are not a year-round full-time employee, basic earnings will be based on your earnings calculated based on your location, for the one-year period preceding the annual enrolment period. Basic earnings do not include bonuses, commissions and overtime for all resorts other than Canadian Mountain Holidays.

For Class CTS: If you are a year-round full-time employee, basic earnings are the hourly base rate of pay for your occupation multiplied by your normal weekly work hours. If you are not a year-round full-time employee, basic earnings will be based on your earnings calculated based on your location, for the one-year period preceding the annual enrolment period. Basic earnings do not include bonuses, commissions and overtime for all resorts other than Canadian Mountain Holidays. If employed less than one year, basic earnings are the hourly base rate of pay for your occupation multiplied by normal weekly work hours and then multiplied by 26 weeks.

For Classes LCM and LMW: Basic earnings on the day immediately preceding your leave start date. Basic earnings will be based on the wages you received from your employer in the one-year period preceding the annual enrolment period. Basic earnings can be calculated on your day rate, or hourly rate, depending on your employee pay type.

For Class LSR: Basic earnings on the day immediately preceding leave start date. Basic earnings are the salary you received from your employer for the one-year period preceding the annual enrolment period, excluding any bonuses, commissions and overtime.

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

Enrolment period The annual enrolment period is the period of time, prior to January 1st of each year, during which you may review your current options and change your options. Please see your plan administrator for further

details on the exact dates. Refer to the *Benefit Details* section for information pertaining to changes in options.

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

Life event change Life event changes include:

- marriage or any other formal union recognized by law, or common-law,
- birth or adoption of a child,
- divorce or legal separation,
- loss of spouse's benefit coverage,
- spouse acquires benefit coverage,
- death of a dependent,
- when a child is no longer an eligible dependent, or
- employment status change.

Off-season An off-season is the months of the year, as determined by the employer and defined by the weather, during which you are not working for the employer and are not covered for any group benefits.

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.

Working-season A working-season is the winter season or the summer season, as determined by the employer and defined by the weather.

Extended Health Care

Plan administrator

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

General description of the coverage

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

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs *(see Prior authorization program for details).*

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

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

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

Benefit year

The benefit year is indicated in the *Benefit Details* section.

Prescription drugs

The reimbursement level is indicated under each option in the *Benefit Details* section. Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*.

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- intrauterine devices (IUDs), diaphragms, diabetic and colostomy supplies.
- products to help you quit smoking up to the reimbursement level and benefit maximum indicated in the *Benefit Details* section.
- products to help you quit smoking up to the reimbursement level and benefit maximum indicated in the *Benefit Details* section.
- vaccines up to the reimbursement level and benefit maximum indicated in the *Benefit Details* section.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.

We will not pay for the following, even when prescribed:

- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements. However, certain anti-obesity drugs may be eligible with prior approval (see Prior authorization program for details).
- hair growth stimulants.
- drugs for the treatment of infertility.

- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug evaluation

The following drugs will be evaluated and must be approved by us to be eligible for coverage:

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

Pharmaceutical services (rendered by pharmacists)

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

Drug substitution limit

Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.

For employees residing in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless Sun Life specifically approved the charges for the higher priced drug.

Prior authorization program

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

In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.

- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

Reference Drug Program

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

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

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

- clinical support for switching to the *Reference Drug*.

- expected duration of treatment.
- provincial programs.

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

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

Québec drug insurance plan

Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet the requirements.

Out-of-pocket maximum

For employees residing in Québec, expenses incurred for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary and not reimbursed under this plan as a result of the application of the deductible or the reimbursement level are limited in each calendar year to the yearly maximum contribution set by the RAMQ plan. There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the employee.

Persons age 65 or over residing in Québec

Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the public prescription drug insurance plan of the Régie de l'assurance-maladie du Québec (RAMQ), which provides basic coverage for prescription drugs costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be insured by either the public plan or your group plan.

If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium.

On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact your benefits administrator to clarify your situation. Unfortunately, we cannot change your file without confirmation from your benefits administrator.

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

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

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Convalescent hospital

We will 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 reimbursement levels for treatment of an illness due to the same or related causes are indicated under each option in the *Benefit Details* section.

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.

Expenses out of your province but within Canada for Classes LCM, LMW, GOL and WOL

We will cover emergency services while you are outside the province where you live but within Canada. We will also cover referred services. The reimbursement levels and the maximum amounts are indicated under each option in the *Benefit Details* section.

For both emergency services and referred services, we will cover the cost of:

- a semi-private hospital room.
- out-patient services in a hospital.
- the services of a doctor.

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

Emergency services

We will only cover emergency services obtained within 60 days of the date you leave the province where you live but within Canada. 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 (ETA) provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Sun Life's ETA provider 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 Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider 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.

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

Sun Life's ETA provider 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, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Sun Life's ETA provider, 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.

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.

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 Sun Life's ETA provider, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any

complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.

- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, 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.

Expenses out of your province for all other Classes

We will cover emergency services while you are outside the province where you live. We will also cover referred services. The reimbursement levels and the maximum amounts are indicated under each option in the *Benefit Details* section.

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 only cover emergency services obtained within 60 days of the date you leave the province where you live (dependent children attending school outside Canada are eligible for coverage). 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 (ETA) provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Sun Life's ETA provider 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 Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider 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 Sun Life's ETA provider, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, 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.

Medical services and equipment

We will cover the cost 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). The reimbursement level is indicated under each option in the *Benefit Details* section.

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. The reimbursement level and the maximum amount we will pay per person are indicated in the *Benefit Details* section.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Reimbursement will be subject to the cost of economy airfare and includes the cost of a medical attendant, if medically necessary, as long as the medical attendant is someone who does not normally live with you.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:

- laboratory tests, including x-ray examinations performed by licensed osteopaths, podiatrists or chiropodists. The maximum amount we will pay per person are indicated in the *Benefit Details* section.
- ultrasounds.
- MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services. The maximum amount we will pay per person are indicated in the *Benefit Details* section.

- x-ray examinations performed by a licensed chiropractor, up to a maximum of $45 per person in a 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. The reimbursement level and the maximum amount we will pay per person are indicated in the *Benefit Details* section.
- wigs following chemotherapy, up to a maximum of $300 per person in a benefit year. Wigs do not require a doctor’s order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.

- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of 2 orthotic inserts per person in a benefit year.
- custom-made orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist. The maximum amount we will pay per person is indicated in the *Benefit Details* section.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $1,500 per person over a period of 60 months. Repairs and replacements 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 lifetime maximum of $700 per person.
- Continuous Glucose Monitor (CGM), including receivers, transmitters, and sensors, for persons diagnosed with Type 1 or Type 2 diabetes requiring insulin use, up to a combined maximum of $4,000 per person per benefit year. You must

provide us with a doctor's note confirming both the diagnosis and insulin use.

Paramedical services

We will cover the costs for paramedical specialists listed in the *Benefit Details* section. The reimbursement level and the maximum amount we will pay per person per benefit year for each category of specialists are indicated under each option in the *Benefit Details* section.

Vision care

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery. Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist and are obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

The reimbursement levels and the maximum amount payable in any 12 month period for a person under age 19 or in any 24 month period for any other person are indicated under each option in the *Benefit Details* section.

We will also pay for services of an ophthalmologist or licensed optometrist, subject to the maximum indicated under each option in the *Benefit Details* section.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.

Payments after coverage ends

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

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

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is

or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integration with government programs

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

The covered expense under this plan is that portion of the expense that is not payable or available under the government program, regardless of:

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or refer to the Sun Life website for available claim forms.

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

- 456 days following the date on which you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage.

Emergency Travel Assistance (Medi-Passport)

This benefit is not applicable to Classes LCM, LMW, GOL and WOL

Plan administrator

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

General description of the coverage

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

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, Sun Life's Emergency Travel Assistance (ETA) provider 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 (dependent children attending school outside Canada are eligible for coverage). 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 Sun Life's ETA provider. If contact with Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider 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.

Sun Life's ETA provider may arrange for:

On the spot medical assistance

Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities.

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

Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel.

Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Sun Life's ETA provider 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, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Sun Life's ETA provider, 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, Sun Life's ETA provider 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.

Sun Life's ETA provider 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 Sun Life's ETA provider, 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

Sun Life's ETA provider 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, Sun Life's ETA provider 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

Sun Life's ETA provider 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, Sun Life's ETA provider 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

Sun Life's ETA provider 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, Sun Life's ETA provider 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 Sun Life's ETA provider coordinate the whole process with most provincial plans and all insurers, and send you a payment for the eligible expenses. Sun Life's ETA provider 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 Sun Life's ETA provider 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 Sun Life's ETA provider:

- 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 Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before your departure.

Sun Life's ETA provider 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 Sun Life's ETA provider to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Sun Life's ETA provider

Neither Sun Life nor Sun Life's ETA provider 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

Plan administrator

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

General description of the coverage

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

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

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

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

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

Reasonable and customary charges mean:

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

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

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

Benefit year

The benefit year is indicated in the *Benefit Details* section.

Reimbursement level

For all eligible expenses, the reimbursement levels are indicated under each option in the *Benefit Details* section.

Benefit year maximum

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

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

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is indicated under each option in the *Benefit Details* section.

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Preventive dental procedures

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

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

Oral examinations

1 complete examination every 24 months.

1 recall examination every 6 months.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 24 months.

1 set of bitewing x-rays every 6 months.

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

Other services

Required consultations between two dentists.

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

Basic dental procedures

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

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

Fillings Amalgam, composite, acrylic or equivalent.

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

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

Repair Repair of bridges or 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.

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

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

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

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

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

The reimbursement level and maximum are indicated under each option in the *Benefit Details* section.

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

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*).

- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

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 12 months after the date of the accident.

What is not covered

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

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

We will not pay for:

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

splinting (capping teeth and joining teeth together to provide additional support).

- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or refer to the Sun Life website for available claim forms. 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 the earlier of:

- 456 days following the date on which you incur the expenses, or
- 90 days after 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.

Health Spending Account

This benefit is not applicable to Classes GOL and WOL

Plan administrator

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

General description of the coverage

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

Your Health Spending Account coverage pays for services or supplies described in this section under *Eligible expenses*.

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

A dependent is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

Benefit year

The benefit year is indicated in the *Benefit Details* section.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses, up to the balance of your account. If a claim exceeds your account balance, the claim will be paid up to the amount in your account and returned to you. You should submit it again once you have the additional credits required. Expenses incurred in one benefit year

for which credits have been allocated can be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why a Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Continuation of coverage for dependents

The Health Spending Account is set up under the employee's name, and there cannot be any continuation of coverage for dependents after the employee's death. Only expenses incurred before the employee's death can be covered under the employee's Health Spending Account.

Plan credits

Your plan credits are indicated in the *Benefit Details* section.

Eligible expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act (Canada) **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act (Canada) is changed, this plan is automatically updated to reflect the changes.

Drugs

- drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses

- eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances

- deductible and coinsurance amounts under medical or dental plans.

Licensed practitioners (fee for services)

- acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapeutists.

Dental care

- preventative, diagnostic, restorative, orthodontic and therapeutic care.

Attendant care

- remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.

- remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.

Facilities

- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.

- payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an

"appropriately qualified person" must certify the individual and his or her special requirements.

Hospitals

- payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.
- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of $1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.

- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.

- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient

who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.

- costs of medical services and supplies outside of the province of residence.
- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
  - equivalent medical services are not available locally.
  - the route is reasonably direct.
  - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the

conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.

- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or refer to the Sun Life website for available claim forms.

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

- 60 days after the end of the benefit year following the benefit year during which you incur the expenses, or
- 90 days after the end of your Health Spending Account coverage.

In certain instances claims may be submitted online if permitted by Sun Life and your employer.

Short-Term Disability

This benefit is not applicable to Classes GUI, LSR, LCM, LMW, NEB, NES, RGC, RGM, RGK, SEB, SLC, SLM, GOL, WOL, SLK and MWG

Insurer

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

General description of the coverage

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

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

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

For the purposes of your Short-Term Disability coverage, you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation.

Your benefits will be based on your coverage on the date you became totally disabled. Benefits are paid at the end of each week for which you are entitled to payments.

When disability payments begin

If you become totally disabled because of an **accident** and your total disability begins within 30 days of the accident, you will be eligible for Short-Term Disability payments on the date you become totally disabled or the first day you consult a doctor, whichever is later.

If you become totally disabled because of an **illness**, you will be eligible for Short-Term Disability payments after 7 days of uninterrupted total disability or the first day you consult a doctor, whichever is later.

In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized.

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

If you are totally disabled for part of any week, we will pay 1/7 of the weekly benefit for each day you are totally disabled.

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 at least 7 uninterrupted days in the case of illness and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer. In the case of an accident, you must be totally disabled on the date you are recalled or scheduled to return to full-time work.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous total disability if it occurs within 30 days of the end of your previous disability. You must be covered when the total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum benefit period.

What we will pay

Here is how we calculate your Short-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take the percentage of your weekly basic earnings as indicated in the *Benefit Details* section. The maximum is also indicated in the *Benefit Details* section.

If your Short-Term Disability benefit is less than the benefit that would be payable under the Employment Insurance Act, your basic earnings

will be increased by any excess of your current salary over the salary you were receiving at the end of the last enrolment period, as well as the amount of bonus, commission, overtime or incentive pay earned on a regular basis, required to calculate the amount of benefit payable under the Employment Insurance Act.

Step 2:

(a) **During the entire period of total disability**, we subtract any income provided to you:

- under a motor vehicle insurance plan which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.
- under a group plan which provides income replacement benefits as a result of an accident or an illness, including a multiple-employer group plan.
- as part of a salary continuance received from your employer during your disability.
- under the Québec Parental Insurance Plan.

(b) **After the first 17 weeks of total disability**, when the maximum benefit period is more than 17 weeks, we also subtract any income provided to you:

- in connection with the same or a subsequent disability under any government-sponsored plan*, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases that occur after benefits begin.
- 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 any coverage resulting from your membership in an association of any kind.

The result from Step 2 is the amount you would normally receive as a Short-Term Disability payment. However, if the amount calculated under Step 2, plus:

- **during the first 17 weeks of total disability** – the sources of income listed in (a) above, exceeds 100% of your pre-disability basic earnings (after income tax, if the benefit is non-taxable),

- **after the first 17 weeks of total disability** – the sources of income listed in (a) and (b) above, exceeds 100% of your pre-disability basic earnings (after income tax, if the benefit is non-taxable),

your Short-Term Disability payment is reduced by the excess.

*If you first become entitled to Québec Pension Plan (QPP) disability benefits:

- before age 60, we will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.

- on or after age 60, we will deduct the amount provided in your NOE and an additional amount. The additional amount represents a portion of the retirement amount, payable or available following an approved QPP disability application, and is comparable to the variable portion of QPP disability benefits for persons under age 60. These deducted amounts will not change for the duration of your disability claim.

If you are entitled to any of the amounts described above, we will estimate the amount of such benefits or income and deduct the estimated amount from your weekly disability benefit when you:

- fail to apply for the benefits or income, or exhaust all levels of appeal.

- fail to make a new application, following a declined application or appeal.

- refuse to receive or accept some or all of the benefits or income, or choose to cancel them.
- fail to provide us with information related to:
  - the status of an application, appeal or reapplication,
  - the benefit or income amount, even if it has been refused or cancelled,

  within 30 days of our request for information.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.

We will not take into account any benefits 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.

Short-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 7 uninterrupted days or the date you are hospitalized if earlier, 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.

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.

When payments end

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

- the date you are no longer totally disabled.
- the end of a maximum benefit period of 26 weeks of payment.
- the date you retire on pension. If you retire while receiving payments, payments will continue for a maximum benefit period of 15 weeks.
- the date you die.

Payments after coverage ends

If the Short-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 on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence*. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks, unless Sun Life agrees in writing in advance to pay benefits during such period or unless the absence is for the purpose of obtaining medical treatment and would be permitted under the Employment Insurance regulations.
- you are serving a prison sentence or are confined in a similar institution.

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

We will not pay for total disability resulting from:

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

When and how to make a claim

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

In order for you to receive benefits, we must receive these forms no later than 6 months after the last day of the month following 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 the request, you will not be entitled to benefits.

Long-Term Disability

This benefit is not applicable to Classes CTS, LSR, LCM, LMW, GUI, RGC, RGM, RGK, SEB, SLC, SLM, GOL, WOL, SLK and MWG

Insurer

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

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 own occupation period (this period is indicated under each option in the *Benefit Details* section), you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

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

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

If 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 26 weeks 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 26 weeks 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 the percentage of your monthly basic earnings as indicated in the *Benefit Details* section. The maximum is also indicated in the *Benefit Details* section.

Step 2: We subtract any income provided to you:

- in connection with 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 first become entitled to Québec Pension Plan (QPP) disability benefits:

- before age 60, we will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.
- on or after age 60, we will deduct the amount provided in your NOE and an additional amount. The additional amount represents a portion of the retirement amount, payable or available following an approved QPP disability application, and is comparable to the variable portion of QPP disability benefits for persons under

age 60. These deducted amounts will not change for the duration of your disability claim.

If you are entitled to any of the amounts described above, we will estimate the amount of such benefits or income and deduct the estimated amount from your monthly disability benefit when you:

- fail to apply for the benefits or income, or exhaust all levels of appeal.
- fail to make a new application, following a declined application or appeal.
- refuse to receive or accept some or all of the benefits or income, or choose to cancel them.
- fail to provide us with information related to:
  - the status of an application, appeal or reapplication,
  - the benefit or income amount, even if it has been refused or cancelled,

within 30 days of our request for information.

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 26 weeks, 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, the Long-Term Disability payments will be reduced by 50% of the income you receive under the rehabilitation program. 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.

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.

For full-time contract employees, these benefits will be based on your coverage as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum benefit period.

If you recover damages from another person

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

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

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 or income that may be available from other sources.

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

When payments end

For full-time contract employees

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. If the elimination period ends after you turn age 64, and before age 65, payments continue for a maximum benefit period of 12 months.
- 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.
- the end of a maximum benefit period of 2 years.

For all other employees

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. If the elimination period ends after you turn age 64, and before age 65, payments continue for a maximum benefit period of 12 months.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

Survivor Benefit

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

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.
- you are not participating in an approved rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off 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 90 days during which you have been actively working continuously (up to 3 days of absence does not count) and you have not been treated by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- you became totally disabled more than 12 months after your coverage began.

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

We will not pay benefits for total disability resulting from:

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

When and how to make a claim

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

We must receive these forms before the earlier of the following dates:

- 6 months after the last day of the month following the end of the elimination period.
- 30 days after the termination of this Long-Term Disability benefit.

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

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

Critical Illness

Insurer

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

General description of the coverage

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

To qualify for this coverage, the person must be a resident of Canada.

Critical Illness coverage for you

Optional coverage

The amount of coverage is indicated in the *Benefit Details* section. The maximum and the minimum are also indicated in the *Benefit Details* section.

Coverage ends

Coverage ends is indicated in the *Benefit Details* section.

Critical Illness coverage for your spouse

Optional coverage

The amount of coverage is indicated in the *Benefit Details* section. The maximum and the minimum are also indicated in the *Benefit Details* section.

Coverage ends

Coverage ends is indicated in the *Benefit Details* section.

What we will pay

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

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

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

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

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

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

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

relative of the covered person, or a person who normally resides in the covered person's household.

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

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

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

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

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

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

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

- employees who are actively working;
- spouses who are not hospitalized; and
- employees and spouses already having Critical Illness coverage

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

If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions. If your spouse is hospitalized when the change occurs, the change will take effect when your spouse is discharged and resumes normal activities and such date will be your spouse's effective date of coverage for the new covered conditions.

In all instances, we will:

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

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

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

- the new plan, including coverage for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all employees and spouses on the effective date of

this plan, regardless of whether the employee is actively working or the spouse is hospitalized on such date;

- for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of coverage is the effective date of this plan; and

- for Critical Illness conditions under this plan which were also covered under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of coverage is the date the person most recently became covered under the previous carrier's plan.

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

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

Covered conditions

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

Aortic Surgery

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

- Exclusion:

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

Aplastic Anemia

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

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

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

Bacterial Meningitis

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

Exclusion:

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

Benign Brain Tumour

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

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

Exclusions:

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

Blindness

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

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

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

Cancer (Life-threatening)

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

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

Exclusions:

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

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

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;

- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

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

Coma

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

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

Exclusions:

No benefit will be payable under this condition for:

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

Coronary Artery Bypass Surgery

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

Exclusion:

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

Deafness

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

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

Dementia, including Alzheimer's Disease

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

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

The covered person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made

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

Exclusion:

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

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

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

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

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

Exclusions:

No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or

- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart Valve Replacement or Repair

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

Exclusion:

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

Kidney Failure

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

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

Loss of Independent Existence

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

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;

- Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

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

Loss of Limbs

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

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

Loss of Speech

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

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

Exclusion:

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

Major Organ Failure on Waiting List

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

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

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

Major Organ Transplant

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

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

Motor Neuron Disease

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

Multiple Sclerosis

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

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

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

Occupational HIV Infection

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

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

- the date the employer receives enrolment information for such amount of coverage; or
- the effective date of such amount of coverage.

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

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

- the accidental injury must be reported to Sun Life within 14 days of the accidental injury;

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

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

Exclusions:

No benefit will be payable under this condition if:

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

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

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

Parkinson's Disease

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

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

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

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

- a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage),

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

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

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

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

Severe Burns

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

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

Stroke (Cerebrovascular Accident)

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

- acute onset of new neurological symptoms; and

- new objective neurological deficits on clinical examination,

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

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

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

Exclusions:

No benefit will be payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

What is not covered

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

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

- intentionally self-inflicted injuries or attempted suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- 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 amount of coverage that:

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

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

- had signs, symptoms, consulted a physician or other health care practitioner; or
- was provided any health-related care, advice or treatment; or
- would have consulted a physician or other health care practitioner, acting as a reasonably prudent person with such injury, sickness, medical condition, signs or symptoms.

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

Portability

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

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

The request must be made within 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.

Sun Life Medical Second Opinion, by Dialogue*

Sun Life Medical Second Opinion services, provided by Dialogue, are not insured or administered by Sun Life.

If you or your spouse are covered for Critical Illness, you, your spouse, your children, your parents and your parents-in-law have access to Sun Life Medical Second Opinion services.

Sun Life Medical Second Opinion includes services to help find a medical specialist, or, when a person has been diagnosed with a serious medical condition, obtain a second opinion from a medical expert, even if it is not a covered condition under this Critical Illness benefit. To learn more, please visit https://luminovc.dialogue.co, or call Dialogue at 1-833-286-5614.

Exclusion of liability

Sun Life and Dialogue will not be held liable for any acts or omissions of any person or organization providing services directly or indirectly in connection with Sun Life Medical Second Opinion services.

*Dialogue is a wholly-owned subsidiary of Sun Life operating as a stand-alone entity.

Life Coverage

Insurer

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

General description of the coverage

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

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

Who we will pay

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

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

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 (or your spouse's estate in the case of Optional Life coverage for your spouse) as beneficiary and provide the executor(s) with directions in your (or your spouse's) will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

Suicide

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

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

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

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

Total disability must continue for:

- 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.

Spouse Optional 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 Spouse Optional Life benefit is terminated.

Child Optional 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 Child Optional 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.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLASS 1

Policy No. 100005332 issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

Classification of Insured Persons	Name or Category of Insured Persons
Class 1	All eligible employees of the Policyholder except Canadian Mountain Holidays Guides.

Section 2

Benefits Classification of Insured Persons	Principal Sum
Class 1	2 times Annual Earnings, adjusted to the next higher $1,000.00 if not already a multiple thereof, subject to a minimum benefit of $30,000.00 and a maximum benefit of $750,000.00. *Reduction Clause:* The Principal Sum shall be reduced by 50% upon attainment of age 65.

You are covered for a principal sum amount of 2 times your annual salary, rounded to the next higher $1,000 if not already a multiple thereof, to a minimum of $30,000 and a maximum of $750,000, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job. The principal sum shall be reduced by 50% upon attainment of age 65.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand	40%
Four Fingers of Either Hand	40%
Hearing in One Ear	40%
All Toes of One Foot	33 1/3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREAVEMENT BENEFIT ($2,500)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six sessions of grief counselling, by a professional counsellor.

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability, subject to continued payment of premiums.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination for all such policies issued to the Policyholder by the Company to a maximum of $500,000.00. Application for conversion must be made within 31 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

CRITICAL DISEASE BENEFIT $50,000)

If an Insured Person, prior to age 65, is diagnosed by a specialist with a Covered Disease while this policy is in force and is totally disabled from the Covered Disease for at least nine months following the date of diagnosis, the Company will pay ten percent of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first covered disease to occur.

"**Covered Disease**" means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pesitis.

DAY CARE BENEFIT ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

EDUCATION BENEFIT ($10,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

EYEGLASSES, CONTACT LENSES AND HEARING AIDS BENEFIT ($1,000)

If, due to injury, an insured requires and receives treatment by a physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expenses actually incurred.

FAMILY TRANSPORTATION BENEFIT ($20,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($50,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to the greater of $15,000 or 10% of the principal sum to a maximum of $50,000.

HOSPITAL INDEMNITY EXPENSE BENEFIT ($2,500)

A daily benefit of 1/30th of 1% of the principal sum will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and begins while this insurance is in force, subject to the above-mentioned monthly maximum.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

REHABILITATION BENEFIT ($20,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training within 3 years.

REPATRIATION BENEFIT ($20,000)

If an injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($20,000)

If an injury results in loss of life, the Company will reimburse the spouse for the reasonable and necessary expenses actually incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM BENEFIT

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

ROTARY-WING AIRCRAFT COVERAGE (PASSENGER)

Coverage includes injury sustained in consequence of riding as a passenger, and not as a pilot or Crew Member, in or on, boarding or alighting from or being struck by or making a forced landing with or from any Rotary-wing aircraft while performing avalanche control, provided such aircraft has a current and valid Certificate of Airworthiness, is being operated at the time with the consent of the Policyholder, and is operated by a person holding a current and valid pilot's license of rating authorizing him to pilot such aircraft.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured attains age 65 for the Critical Disease Benefit and age 70 for all other benefits; (d) the premium due date next following the date an insured becomes ineligible for coverage, except as provided under the Continuation of Coverage.

WHEN DOES THIS INSURANCE NOT APPLY?

The policy does not cover loss, fatal or non-fatal, caused by or contributed to, directly or indirectly resulting from:

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the Limited Air Travel Coverage and Rotary-wing Aircraft coverage (passenger) Benefits;
- physical or mental illness or disease or treatment for the illness or disease, except as provided in the Critical Disease Benefit.

Nor does the policy cover expenses incurred:

for the purchase, repair or replacement of eyeglasses or contact lenses or prescriptions therefor, except as provided in the Eyeglasses, Contact Lenses and Hearing Aids Benefit.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

Bereavement Benefit	Family Transportation Benefit
Day Care Benefit	Repatriation Benefit
Education Benefit	Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

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BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLASS 2

Policy No. 100005332 issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

Classification of Insured Persons	Name or Category of Insured Persons
Class 2	All Canadian Mountain Holidays guides.

Section 2

Benefits Classification of Insured Persons	Principal Sum
Class 2	$75,000.00.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are covered for a principal sum amount of $75,000, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand	40%
Four Fingers of Either Hand	40%
Hearing in One Ear	40%
All Toes of One Foot	33 1/3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREAVEMENT BENEFIT ($2,500)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six sessions of grief counselling, by a professional counsellor.

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability, subject to continued payment of premiums.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination for all such policies issued to the Policyholder by the Company to a maximum of $500,000.00. Application for conversion must be made within 31 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

CRITICAL DISEASE BENEFIT $50,000)

If an Insured Person, prior to age 65, is diagnosed by a specialist with a Covered Disease while this policy is in force and is totally disabled from the Covered Disease for at least nine months following the date of diagnosis, the Company will pay ten percent of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first covered disease to occur.

"**Covered Disease**" means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pesitis.

DAY CARE BENEFIT ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

EDUCATION BENEFIT ($10,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

EYEGLASSES, CONTACT LENSES AND HEARING AIDS BENEFIT ($1,000)

If, due to injury, an insured requires and receives treatment by a physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expenses actually incurred.

FAMILY TRANSPORTATION BENEFIT ($20,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($50,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to the greater of $15,000 or 10% of the principal sum to a maximum of $50,000.

HOSPITAL INDEMNITY EXPENSE BENEFIT ($2,500)

A daily benefit of 1/30th of 1% of the principal sum will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and begins while this insurance is in force, subject to the above-mentioned monthly maximum.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

REHABILITATION BENEFIT ($20,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training within 3 years.

REPATRIATION BENEFIT ($20,000)

If an injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($20,000)

If an injury results in loss of life, the Company will reimburse the spouse for the reasonable and necessary expenses actually incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM BENEFIT

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

ROTARY-WING AIRCRAFT COVERAGE (PASSENGER)

Coverage includes injury sustained in consequence of riding as a passenger, and not as a pilot or Crew Member, in or on, boarding or alighting from or being struck by or making a forced landing with or from any Rotary-wing aircraft while performing avalanche control, provided such aircraft has a current and valid Certificate of Airworthiness, is being operated at the time with the consent of the Policyholder, and is operated by a person holding a current and valid pilot's license of rating authorizing him to pilot such aircraft.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured attains age 65 for the Critical Disease Benefit and age 70 for all other benefits; (d) the premium due date next following the date an insured becomes ineligible for coverage, except as provided under the Continuation of Coverage.

WHEN DOES THIS INSURANCE NOT APPLY?

The policy does not cover loss, fatal or non-fatal, caused by or contributed to, directly or indirectly resulting from:

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the Limited Air Travel Coverage and Rotary-wing Aircraft Coverage Benefits;
- physical or mental illness or disease or treatment for the illness or disease, except as provided in the Critical Disease Benefit.

Nor does the policy cover expenses incurred:

for the purchase, repair or replacement of eyeglasses or contact lenses or prescriptions therefor, except as provided in the Eyeglasses, Contact Lenses and Hearing Aids Benefit.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

Bereavement Benefit
Day Care Benefit
Education Benefit
Family Transportation Benefit
Repatriation Benefit
Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

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VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SUMMARY OF INSURANCE COVERAGE
Policy No. 100005333 issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

Classification of Insured Persons	**Name or Category of Insured Persons**
Class 1	All active employees of the Policyholder, who are performing the regular duties of their occupation on a full-time basis on the date of their application, for whom the applicable premium has been paid.
Class 2	Spouse of Class 1 Participant, for whom the applicable premium has been paid.
Class 3	Dependent Child of Class 1 Participant, for whom the applicable premium has been paid.

Section 2

Benefits Classification of Insured Persons	**Principal Sum**
Classes 1 &2	$25,000.00 or any multiple of $25,000.00 to a maximum of $500,000.00 as specified in the application for insurance submitted by the Participant and for which the appropriate premium has been paid.
Class 3	$10,000.00 or any multiple of $10,000.00 to a maximum of $50,000.00 as specified in the application for insurance submitted by the Participant and for which the appropriate premium has been paid.

Coverage

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If you elect to participate, you are covered for injuries sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job, for the principal sum amount you have selected. You may select any principal sum of insurance from a minimum of $25,000 to a maximum of $500,000, in units of $25,000.

You may also select any principal sum of insurance from a minimum of $25,000 to a maximum of $500,000, in units of $25,000 for your spouse and any principal sum of insurance from a minimum of $10,000 to a maximum of $50,000, in units of $10,000 for each of your dependent child.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The “loss” or “loss of use” must occur within 365 days after the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand	40%
Four Fingers of Either Hand	40%
Hearing in One Ear	40%
All Toes of One Foot	33 1/3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREAVEMENT BENEFIT ($2,500)

If an injury results in loss of life of a participant, the Company will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the participant for up to 6 sessions of grief counselling, by a professional counsellor.

CHILD ENHANCEMENT BENEFIT

With the exception of loss of life, all amounts provided under the Accidental Death, Dismemberment and Specific Loss Indemnity are doubled with respect to insured dependent children, subject to two times the principal sum, but in no event will exceed the maximum of $50,000.

COMMON DISASTER BENEFIT ($1,000,000)

In the event of the accidental death of both the participant and his/her insured spouse and provided benefits for such loss become payable as a result of the same accident and both deaths occur within 90 days of the accident, the principal sum applicable to the insured spouse will be increased to the amount of the participant's principal sum.

CONTINUATION OF COVERAGE

Coverage can be continued while the participant is on an approved leave of absence, maternity/parental leave, lay-off or disability, subject to continued payment of premiums.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, a participant may convert his/her insurance only (and not that of his/her insured spouse or insured dependent children) to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination for all such policies issued to the Policyholder by the Company to a maximum of $500,000.00. Application for conversion must be made within 31 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

CRITICAL DISEASE BENEFIT

If an Insured Person, prior to age 65, is diagnosed by a specialist with a Covered Disease while this policy is in force and is totally disabled from the Covered Disease for at least nine months following the date of diagnosis, the Company will pay ten percent of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first covered disease to occur.

"**Covered Disease**" means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pestis.

DAY CARE BENEFIT ($5,000)

If an injury results in loss of life of a participant, the Company will pay 5% of the principal sum for each dependent child who is under age 13 and enrolled in a legally licensed day care centre on the date of, or within 12 months following the accident, for each year the dependent child is enrolled in the day care (not to exceed 4 years).

EDUCATION BENEFIT ($10,000)

If an injury results in loss of life of a participant, the Company will pay 5% of the principal sum for each dependent child who is enrolled as a full-time student in any institution of higher learning beyond the secondary school level on the date of, or within 12 months following the accident, for each year the dependent child continues his/her education in an institution of higher learning (not to exceed four years). If, at the time of loss, none of the

dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

EXTENDED FAMILY BENEFIT

If an injury results in loss of life of a participant, and his/her spouse and dependent children are insured under this plan at the time of the death, this insurance may be continued for the insured spouse and insured dependent children for up to 6 months provided premiums are paid.

EYEGLASSES, CONTACT LENSES AND HEARING AIDS BENEFIT ($1,000)

If, due to injury, an insured requires and receives treatment by a physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 12 months of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expenses actually incurred.

FAMILY TRANSPORTATION BENEFIT ($20,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by an immediate family member for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($50,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to the greater of $15,000 or 10% of the principal sum to a maximum of $50,000.

HOSPITAL INDEMNITY EXPENSE ($2,500)

A daily benefit of 1/30th of 1% of the principal sum will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and begins while this insurance is in force, subject to the above-mentioned monthly maximum.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

REHABILITATION BENEFIT ($20,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and requires that the participant undergo special training in order to be qualified to engage in a special occupation in which the participant would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training within 3 years.

REPATRIATION BENEFIT ($20,000)

If an injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($20,000)

If an injury results in loss of life of a participant, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM BENEFIT

In the event a participant becomes totally disabled and waiver of premium has been approved and accepted by the Group Life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

ROTARY-WING AIRCRAFT COVERAGE (PASSENGER)

Coverage includes injury sustained in consequence of riding as a passenger, and not as a pilot or Crew Member, in or on, boarding or alighting from or being struck by or making a forced landing with or from any Rotary-wing aircraft while performing avalanche control, provided such aircraft has a current and valid Certificate of Airworthiness, is being operated at the time with the consent of the Policyholder, and is operated by a person holding a current and valid pilot’s license of rating authorizing him to pilot such aircraft.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will immediately terminate on the earliest of:

A. For the participant: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the participant’s premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date a participant attains age 65 for the Critical Disease Benefit and

attains age 70 for all other benefits; (d) the premium due date next following the date a participant is ineligible for coverage, except as provided under the Continuation of Coverage.

B. For the insured spouse and/or insured dependent child: (a) the date such person becomes ineligible for coverage; and (b) the date the participant's insurance is terminated.

WHEN DOES THIS INSURANCE NOT APPLY?

The policy does not cover loss, fatal or non-fatal, caused by or contributed to, directly or indirectly resulting from:

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the Limited Air Travel Coverage and Rotary-wing Aircraft coverage (Passenger) Benefits;
- physical or mental illness or disease or treatment for the illness or disease, except as provided in the Critical Disease Benefit.

Nor does the policy cover expenses incurred:

- for the purchase, repair or replacement of eyeglasses or contact lenses or prescriptions therefor, except as provided in the Eyeglasses, Contact Lenses and Hearing Aids Benefit.

BENEFICIARY

Indemnity payable in the event of the loss of life of a participant is payable to the beneficiary or beneficiaries designated in writing by the participant on his enrolment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the participant, such indemnity is payable to the estate of the participant. All other indemnities payable, including those payable for the insured spouse and/or insured dependent children, are payable to the participant, with the exception of indemnities payable under the following benefits:

Bereavement Benefit	Family Transportation Benefit
Day Care Benefit	Repatriation Benefit
Education Benefit	Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the participant.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

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(JAN/2024)

Respecting your privacy

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

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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).