Sun Life Financial

your group benefits

Konica Minolta Business Solutions (Canada) Ltd.

Regular Employees

Contract Number 100955 and 150355
Effective January 1, 2013

Table of Contents

Benefit Details

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

Your Extended Health Care options

	Basic	Comprehensive	Enhanced
Prescription drugs	60%	80%	90%
Reimbursement Level	For prescription drugs only, the reimbursement level described above applies to the first $2,000 of expenses per person per benefit year. Thereafter, any eligible expenses in excess of $2,000 per person per benefit year are paid at 100%.	For prescription drugs only, the reimbursement level described above applies to the first $1,500 of expenses per person per benefit year. Thereafter, any eligible expenses in excess of $1,500 per person per benefit year are paid at 100%.	For prescription drugs only, the reimbursement level described above applies to the first $1,000 of expenses per person per benefit year. Thereafter, any eligible expenses in excess of $1,000 per person per benefit year are paid at 100%.
	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	Not covered	100% semi-private room	100% private room
Convalescent hospital Maximum	Not covered	80% $20 per day up to 180 days	100% $20 per day up to 180 days
Expenses out of your province	Emergency – 100% Referral – Not covered	Emergency – 100% Referral – Not covered	Emergency – 100% Referral – 80%
Medi-Passport	Covered	Covered	Covered
Private duty nursing Max. per 3 years	Not covered	80% $25,000 per person	90% $25,000 per person

	Basic	Comprehensive	Enhanced
Medical services and equipment	Not covered	80%	90%
Paramedical services Max. per benefit year	Not covered	80% $500 per specialty and an overall combined maximum of $1,000 per person for all paramedical services	90% $1,500 overall combined maximum per person for all paramedical services
Vision care Maximum per 24 months	Not covered	100% $300 per person	100% $400 per person
Eye Exams Max. per benefit year	Not covered	100% $60 per person	100% $60 per person
Benefit year maximum	For prescription drugs only – $100,000 per person		
Overall maximum	Out-of-Canada emergency services – lifetime maximum of $3,000,000 per person All other expenses combined – lifetime maximum of $5,000,000 per person		
Benefit year	January 1st to December 31st		
Changes in options	You can change your option during the annual enrolment period or within 31 days of a *life event change*. Proof of good health is not required.		
Coverage ends	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.		

Your Dental Care options

	Basic	Comprehensive	Enhanced
Preventive	80%	100%	100%
Recall exam, Bitewing x-rays, Polishing / Fluoride, Oral Hygiene	80% every 6 months for a person under age 18, and 9 months for any other person	100% every 6 months for a person under age 18, and 9 months for any other person	100% every 6 months
Basic	60%	80%	90%
Major	Not covered	50%	60%
Orthodontics	Not covered	50%	60%

	Basic	Comprehensive	Enhanced
Benefit year maximum	$500 for Preventive and Basic combined	$1,500 for Preventive, Basic and Major combined	$2,500 for Preventive, Basic and Major combined
Lifetime maximum	Not applicable	$1,500 for Orthodontics	$3,000 for Orthodontics
Benefit year	January 1st to December 31st		
Changes in options	You can change your option during the annual enrolment period or within 31 days of a *life event change*. Proof of good health is not required.		
Coverage ends	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.		

Your Health Spending Account (Available only with Basic Option)

Benefit year	January 1st to December 31st
Plan Credits	On the first day of each benefit year, the remaining flex credits are allocated to the account. Flex credits are determined by your employer and are subject to change. You must have a minimum of 50 flex dollars to open a Health Spending Account.
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 Personal Spending Account (Available only with Basic Option)

Benefit year	January 1st to December 31st
Credits	On the first day of each benefit year, the remaining flex credits are allocated to the account. Flex credits are determined by your employer and are subject to change You must have a minimum of 50 flex dollars to open a Personal Spending Account.
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 Long-Term Disability coverage

Coverage	66.67% of the first $2,250 of your monthly basic earnings, add 50% of the next $3,500 and then add 44% of the balance of your monthly earnings, if any, up to a maximum benefit of $10,000.
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	$200,000
Minimum	$20,000
Proof of good health	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.
	In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.
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 Critical Illness coverage for your spouse

Coverage	As elected by the employee, units of $10,000
Maximum	$200,000
Minimum	$20,000
Proof of good health	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.
	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.

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 Critical Illness coverage for your children

Coverage	As elected by the employee, units of $5,000
Maximum	$20,000
Proof of good health	Required when you request optional coverage, except if the request for coverage is made within 31 days of eligibility.
	In addition, coverage for any child will end on the date a Critical Illness benefit is paid for a covered condition which that child sustains.
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 – Core benefit

Coverage	1 times your annual basic earnings rounded to the next higher $1,000
Maximum	$500,000
Minimum	$50,000
Proof of good health	Not required
Coverage reduces	To 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 $10,000
Maximum	$200,000
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 $10,000
Maximum	$200,000
Proof of good health	Proof of good health of your spouse is 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*.

Optional Life coverage for your children

Coverage	As elected by the employee, units of $5,000
Maximum	$20,000
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*.

General Information

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

About this booklet

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contracts with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies, as described below.

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 105655 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, Konica Minolta Business Solutions (Canada) Ltd., has entered into an Administrative Services Contract with Sun Life for the Health Spending Account benefit. The contract self-insures this benefit. This means the contract holder has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

In addition, the contract holder has established a Personal Spending Account and entered into a Personal Spending Account Services Contract with Sun Life. The contract holder has the sole legal and financial liability for the Personal Spending Account and Sun Life only acts as administrator.

Eligibility

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

- you are a regular employee.
- you are a permanent employee.
- you are actively working for your employer at least 28 hours a week.
- you have completed the waiting period.

The waiting period for your group plan as communicated by your employer.

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 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 25 (age of 26 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 ***Comprehensive Single*** coverage. For a dependent to receive coverage, you must request dependent coverage.

You may only enrol for Employee Critical Illness if you are under age 65. You may only enrol for Spouse Critical Illness if your spouse is under age 65.

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

There are other cases when you will be required to provide proof of

good health. Your employer will let you know when this is necessary.

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

For Dependent Life, Extended Health Care and Dental Care benefits, once you have dependent coverage, any subsequent dependents will be covered automatically. Once a child is covered for Child Optional Critical Illness, any subsequent children are automatically covered for this benefit.

If you are not actively working on the date Optional Life or Optional Critical Illness coverage for your spouse or children 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 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.

For the Life and Long-Term Disability coverage, any change in coverage resulting from a change in salary will take effect on the date of the change in circumstances.

For changes requested due to a *life event change,* subject to the exceptions below, the change in coverage is effective on the date of the change in circumstance.

All other changes in coverage will take effect on the first day of the month following the annual enrolment period.

For a person earning sales commissions, any change in coverage resulting from a change in basic earnings will take effect on the following January 1st. If the earnings change takes effect on January 1st , then the change in coverage will take effect on that same day.

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

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

- our Sun Life Financial Plan Member Services website at www.mysunlife.ca.
- our Sun Life Financial Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

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

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

- the date the group contract ends.

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

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

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

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

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

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

Making claims

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

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

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

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

Legal actions

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

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for disability benefits that have been paid by Sun Life for some period of time, more than one year after the last date for which disability benefits have been paid, or

- regarding all other claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim, or
- regarding claims for *Coverage during total disability* which are initially approved, more than one year after the date you cease to be covered or your premiums cease to be waived.

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

Assignments

For Life benefits, no rights or interests can be assigned.
For all other benefits, we reserve the right to refuse assignments.

Definitions

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

Accident

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

Appropriate treatment

Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Basic earnings

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

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

Classes

Class A – Senior Executives (Non-Québec)
Class AQ – Senior Executives (Québec)
Class B – Non-Union Employees (Non-Québec)
Class BQ – Non-Union Employees (Québec)
Effective February 1, 2013
Class F – Union Employees Flex Plan (Non-Québec)

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 for a two week period between November 1 to November 30.

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

Life event change Life event changes include:

- marriage or any other formal union recognized by law, or common-law,
- birth or adoption of a child,
- divorce or legal separation,
- loss or gain of spouse's benefit coverage, or
- death of a dependent.

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

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

Extended Health Care

General description of the coverage

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *Medically necessary* means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

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

Benefit year

The benefit year is indicated in the Benefit Details section.

Deductible (Classes AQ and BQ)

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

For employees residing in Québec, the deductible for prescription drugs is $8 for each prescription or refill. The prescription drug deductible ceases to be applied for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached.

For other expenses, there is no deductible.

Lifetime maximum benefit

Under Extended Health Care, the maximum amount we will pay is indicated under each option in the Benefit Details section.

There is an automatic reinstatement each benefit year of up to $1,000 of benefits paid but not previously reinstated. This reinstatement will be made on the first day of each benefit year.

Benefit year maximum

For prescription drugs only, the maximum amount we will pay is indicated under each option in the Benefit Details section.

Prescription drugs

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 covered under this plan must have a Drug Identification Number (DIN) in order to be eligible. The reimbursement level is indicated under each option in the Benefit Details section.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of sexual dysfunction, up to a maximum of $1,000 per person in a benefit year.
- drugs for the treatment of infertility, up to a lifetime maximum of $2,400 for each person.
- vaccines, up to a lifetime maximum of $3,000 per person.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

We will also cover the cost of products to help a person quit smoking that have a Drug Identification Number (DIN) or a Natural Product Number (NPN), up to a lifetime maximum of $500 for each person,

provided that they are prescribed by a doctor or dentist and obtained from a pharmacist.

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

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN), except as otherwise provided under the list of eligible expenses above.
- 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.

Dispensing fee Classes A and B (effective February 1, 2013, Class F)

Eligible expenses for the dispensing fee are limited to $8 for each prescription or refill, and are covered at 100%.

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, the drug substitution limit is applied as long as the drug expenses actually paid by the plan are not lower than the minimum set by the Régie de l'assurance-maladie du Québec and the out-of-pocket maximum for prescription drug expenses has not been reached.

Maintenance program

The maintenance program is designed for people taking an eligible drug for a prolonged period (more than 3 months). This program provides you with the option to purchase up to a 3 month supply of the drug at one time, which will be reimbursed under your plan. You are not required to participate. It is up to you to let the pharmacist know if you are interested.

When you use your drug card at the pharmacy, and our system shows that you have had 3 consecutive 30 day prescriptions for the same drug, the pharmacist will ask you if you are interested in a 3 month supply. If you agree, the pharmacist will contact your doctor for approval.

The program includes all drugs used for the treatment of chronic health conditions, for example high blood pressure and high cholesterol.

As a safeguard, the program does not include narcotics or controlled medications.

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

For any drugs payable in part by the Régie de l'assurance-maladie du Québec (RAMQ) for persons age 65 and over covered by the RAMQ drug insurance plan, coverage is adjusted so that the drug expenses actually paid for by this plan and the RAMQ plan do not exceed the amount that would have been covered had you participated in this plan only.

Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the RAMQ's public prescription drug insurance plan, 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 in the province where you live, 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

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 90 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

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

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

If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are

provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when you are medically stable to return to the province where you live.

Emergency services excluded from coverage

Any expenses related to the following emergency services are not covered:

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you unreasonably 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.

Private duty nursing

We will cover out-of-hospital private duty nurse services when medically necessary. Services must be ordered by a doctor and 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 is indicated under each option in the Benefit Details section.

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.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified in the Benefit Details section for emergency services under Expenses out of your province.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified in the Benefit Details section for emergency services under Expenses out of your province.

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined lifetime maximum of $3,000 per person.
- 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, up to a lifetime maximum of $3,000 per person. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- wigs following chemotherapy, up to a maximum of $500 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 a lifetime maximum of $2,000 for a non-electric wheelchair and a lifetime maximum of $4,000 for an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of 2 prostheses 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, up to a maximum of $2,000 per person in a benefit year.
- artificial eyes, up to a maximum of $1,000 per person in a benefit year.
- 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 $100 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 $350 per person in a benefit year.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $350 per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of $1,000 per person.
- insulin pumps.
- TENS machine, up to a lifetime maximum of $2,000 per person.
- fiberglass and walking cast.

Paramedical services

We will cover reasonable and customary costs for paramedical specialists listed below. The reimbursement level and the maximum amount we will pay per person per specialty in a benefit year are indicated under each option in the Benefit Details section.

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

Vision care

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

The reimbursement level and the maximum amount payable in any 24 month period are indicated under each option in the Benefit Details

section.

We will also cover the costs for services of an ophthalmologist or licensed optometrist. The reimbursement level and the maximum amount payable are indicated under each option in the Benefit Details section.

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

We will not pay for safety glasses or magnifying glasses of any kind.

Payments after coverage ends

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

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

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

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or

supplies are provided.

- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integration with government programs

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

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

- whether you have made an application to the government program,
- whether coverage under this plan affects your eligibility or

entitlement to any benefits under the government program, or

- any waiting lists.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

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

Emergency Travel Assistance (Medi-Passport)

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (*Europ Assistance*) can help.

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 90 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

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

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

Getting help

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

emergency.

Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card.

Europ Assistance may arrange for:

On the spot medical assistance

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

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

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

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

Transportation home or to a different medical facility

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

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

Sun Life or Europ Assistance, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.

Meals and accommodations expenses

If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Europ Assistance will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days.

Europ Assistance will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Europ Assistance, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.

Travel expenses home if stranded

Europ Assistance will arrange and, if necessary, advance funds for transportation to the province where you live:

- for you, if due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated; or
- for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

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

We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.

Travel expenses of family members

Europ Assistance will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the place where you are hospitalized if you are hospitalized for more than 7 consecutive days, and:

- you are travelling alone, or
- you are travelling only with a child who is under the age of 16 or

mentally or physically handicapped.

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

Repatriation

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

Vehicle return

Europ Assistance will arrange and, if necessary, advance funds up to $500 for the return of a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from returning the vehicle.

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Europ Assistance will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

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

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association.

The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Limits on advances

Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.

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

Reimbursement of expenses

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

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

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Europ Assistance:

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.
- amounts paid for services or supplies not covered by this plan.
- amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

Limits on Emergency Travel Assistance coverage

There are countries where Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.

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

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

strike, nuclear accident or an act of God.

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

Liability of Sun Life or Europ Assistance

Neither Sun Life nor Europ Assistance will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Care

General description of the coverage

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

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

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

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

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

For Comprehensive and Enhanced Option – 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 usual and reasonable charge for the final dental service.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure 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.

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, up to the limit indicated under each option in the Benefit Details section.

Emergency or specific examinations.

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

1 set of bitewing x-rays, up to the limit indicated under each option in the Benefit Details section.

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, up to the limit indicated under each option in the Benefit Details section.

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, up to the limit indicated under each option in the Benefit Details section.

Special visits limited to a maximum of $250 per person per benefit year.

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 and gold foil restorations Amalgam, composite, acrylic or equivalent fillings. Gold foil restorations will be reimbursed up to the cost of Amalgam or composite fillings.

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, including 8 units of scaling and root planing per benefit year.

Temporomandibular joint (TMJ) treatment. Limited to once every 4 years.

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

The following procedures are limited as indicated below:

- surgical exposure of a tooth (transplantation of a tooth), up to a maximum of $150 per benefit year.
- surgical repositioning of a tooth, up to a maximum of $150 per benefit year.
- treatment of mandibular fractures - open reduction, up to a maximum of $750 per benefit year.
- treatment of maxillary fractures - open reduction, up to a maximum of $750 per benefit year.

Repair Repair of dentures.

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

Major dental procedures

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

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*).

Repair Repair of bridges.

Prosthodontics Construction and insertion of bridges or standard dentures. 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.

Only children under age 20 are covered for these procedures.

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 6 months after the date of the accident, up to a lifetime maximum of $3,000 per person.

What is not covered

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

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

We will not pay for:

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

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

We will also not pay for dental work resulting from:

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca. The dentist will have to complete a section of the form.

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

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

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

Health Spending Account (Available only with Basic Option)

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 a person as defined under *Who qualifies as your dependent.*

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. The amount of credits must be determined at the beginning of each benefit year and will be allocated to your Health Spending 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. Expenses incurred in one benefit year cannot 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 the 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.

If your coverage starts after the commencement of the benefit year, your plan credits are adjusted based on the number of days remaining in that benefit year.

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 health or dental coverage under another plan, it is to your advantage to submit your claims to the other plan first. Once benefits have been determined under the other plan,

you can submit a claim for reimbursement of any unpaid portion 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.

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

- 90 days after the end of the benefit year during which you or a dependent incur the eligible expenses, or
- 90 days after the end of your Health Spending Account coverage, whichever is earlier.

Personal Spending Account (Available only with Basic Option)

General description of the coverage

The contract holder has established a Personal Spending Account and has the sole legal and financial liability for this Personal Spending Account under the Personal Spending Account Services Contract entered into with Sun Life. Sun Life only acts as administrator.

Your employer will be responsible for all payroll related deductions and issuing the appropriate tax information slips related to your Personal Spending Account.

Your Personal Spending Account coverage provides reimbursement to you for expenses described in this section under *Eligible expenses*.

An eligible expense is incurred on the date the expense is billed. Eligible expenses incurred by your dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Personal Spending Account and before the date the Personal Spending Account ends.

A dependent is a person as defined under *Who qualifies as your dependent.*

The benefit year is from January 1 to December 31.

How your Personal Spending Account works

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

Each time you submit a Personal Spending Account claim, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Personal Spending Account.

Personal Spending Account with no carry-forward feature

We must receive claims for any eligible expenses incurred in a benefit year no later than 90 days after the end of the benefit year during which the eligible expenses are incurred, or 90 days after your Personal Spending Account coverage ends, whichever is earlier. Please see *When and how to make a claim.*

Any credits remaining in your Personal Spending Account at the end of the benefit year will be lost.

Surviving dependent coverage

The Personal Spending Account is set up under the employee's name, and there is no continuation of coverage for dependents after the employee's death. Only eligible expenses incurred before the employee's death can be reimbursed under the employee's Personal Spending Account.

Credits

Remaining Flex credits at the beginning of each benefit year

If your coverage starts after the benefit year begins, your credits are adjusted based on the number of days remaining in that benefit year.

Eligible expenses

You can use your Personal Spending Account to help you pay for the following eligible expenses:

Fitness-related services

- fitness club memberships.
- registration fees for fitness-related programs or lessons, such as aerobic classes, yoga, dance lessons and figure skating.
- annual memberships, such as golf, racquet clubs.
- personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.

Fitness equipment

- durable equipment such as treadmills, exercise bikes and universal gym.

Health-related services

- weight management programs (excluding food).
- smoking cessation programs.

- nutrition programs and counselling.
- maternity services (prenatal classes and mid-wife services).
- services of the following alternative health practitioners: reflexologist, iridologist, herbalist, homeopath, athletic therapist, Chinese medical practitioner, Shiatsu therapist, osteopathic practitioner and acupressurist.
- stress management programs.
- cholesterol and hypertension screening.
- first aid and CPR (cardiopulmonary resuscitation) training.
- health assessments.
- allergy tests.
- vitamins and supplements, including herbal products.
- other alternative wellness services: Reiki, Ayurvedic medicine, touch therapy, Rolfing and light therapy.

Insurance premiums

- insurance premiums paid for Critical Illness, Life and Long Term Care.

Work-life balance

- child care expenses.
- elder care expenses.

Professional services

- services of professionals for estate planning, financial counselling, tax return preparation and will preparation.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

- 90 days after the end of the benefit year during which the eligible expenses are incurred, or
- 90 days after the end of your Personal Spending Account coverage, whichever is earlier.

Long-Term Disability

General description of the coverage

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

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

For your Long-Term Disability coverage,

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

If you 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:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your

membership in an association of any kind.

- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under the Québec Parental Insurance Plan.

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

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

Additional sources of income provided to you:

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

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

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

We will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

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

Maternity / parental leave of absence

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

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

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

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

If you recover damages from another person

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

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

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

We have the right to withhold or discontinue disability income

payments if you refuse or fail to comply with any of these terms.

Your responsibilities

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

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

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

When payments end

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

- the date you are no longer totally disabled.
- the last day of the month in which you reach age 65.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

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

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

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

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

We will not consider you totally disabled if your disability results from drug or alcohol abuse. However, this limitation will not apply while you are participating in a Sun Life approved treatment program or you have an organic disease which would cause total disability even if drug

and alcohol abuse ended.

We will not pay benefits for total disability resulting from:

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

When and how to make a claim

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

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

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

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

In order to receive benefits, we must receive these forms no later than 90 days after the end of the elimination period.

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

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

Critical Illness

General description of the coverage

Critical Illness coverage provides a benefit if, after the effective date of coverage, a diagnosis is made that you or your dependent (spouse or child) have experienced a covered condition, or have had surgery for a covered condition, as indicated below under *What we will pay*.

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

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

What we will pay

We will pay the Critical Illness benefit if, after the effective date of coverage, a diagnosis is made that you or your dependent (spouse or child) have experienced a covered condition, or have had surgery for a covered condition, subject to the survival period.

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

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

Diagnosis

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

Life support

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

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

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

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

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

Who we will pay

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

Covered conditions for employees, spouses and children

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

Alzheimer's disease Alzheimer's disease means a definite diagnosis of a progressive degenerative disease of the brain. The covered person must exhibit the

loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision.

The diagnosis of Alzheimer's disease 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 for all other dementing organic brain disorders and psychiatric illnesses.

Aortic surgery Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to 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.

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:

No benefit will be payable for benign brain tumour and the covered person's coverage for benign brain tumour will terminate if, within 90 days following the later of:

- the date Sun Life receives enrolment information for the person's coverage; or,
- the effective date of the person's 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;
- a diagnosis of benign brain tumour (covered or excluded under this coverage).

While the covered person's coverage for benign brain tumour terminates, coverage for all other covered conditions remains in force.

This information described above must be reported to us within 6 months of the date of diagnosis. If this information is not provided, we have 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, we 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 Cancer means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

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

Exclusions:

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

No benefit will be payable under this condition for the following non-life threatening cancers:

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

Moratorium Period Exclusion:

No benefit will be payable for cancer and the covered person's coverage for cancer will terminate if, within 90 days following the later of:

- the date Sun Life receives enrolment information for the person's coverage; or,
- the effective date of the person's coverage,

the covered person has any of the following:

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

While the covered person's coverage for cancer terminates, coverage for all other covered conditions remains in force.

This information described above must be reported to us within 6 months of the date of diagnosis. If this information is not provided, we have 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, we will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

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; or,
- 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), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

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.

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.

Heart attack

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

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

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

Exclusions:

Heart attack does not include:

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

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 either:

- a total inability to perform, by oneself, at least 2 of the following 6 activities of daily living; or,
- cognitive impairment, as defined below,

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 equipment.
- Dressing: the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting: the ability to get on and off the toilet and maintain personal hygiene.

- 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 use of equipment.

- Feeding: the ability to consume food or drink that already have been prepared and made available, with or without the use of adaptive utensils.

Cognitive impairment means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a specialist physician. The degree of cognitive impairment must be sufficiently severe to require a minimum of 8 hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

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.

Exclusion:

No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

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. The covered person must survive for 180 days following the date of diagnosis.

Exclusion:

No benefit will be payable under this condition for all 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.

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 for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

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 their transplant.

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; or,
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system,

showing multiple lesions of demyelination; or,

- a single attack, confirmed by repeated MRI imaging 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.

The accidental injury leading to the infection must have occurred after the later of:

- the date Sun Life receives enrolment information for the person's coverage; or,
- the effective date of the person's coverage.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, we 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 us 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;
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian 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; or,
- a licensed cure for HIV infection has become available prior to 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 idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

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

Exclusion:

No benefit will be payable under this condition for all other types of Parkinsonism.

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; and,

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

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

Covered conditions for children only

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

You cannot apply for Critical Illness coverage for children until you have children who are living.

Children may be subject to either the *Child moratorium period exclusion* or the *Pre-existing conditions* provision as described below. When applicable, the *Child moratorium period exclusion* and the *Pre-existing conditions* provision apply to all covered conditions for which the child is covered.

For children:

- who are the children of you or your spouse and are born during the period beginning 90 days prior to the date you become covered for Child Critical Illness and ending 10 months after such date, the *Child moratorium period exclusion* applies.

- who are the children of you or your spouse and are born or adopted later than 10 months after the date you become covered for Child Critical Illness, neither the *Child moratorium period exclusion* or the *Pre-existing conditions* provision apply.

- other than those described above, the *Pre-existing conditions* provision applies unless proof of good health is required for the child's coverage.

Critical Illness coverage may terminate for one child but continue for your other children. In the event that you only have one child living for whom coverage ends, then your Critical Illness coverage for children terminates.

References to a covered person include children.

Cerebral palsy

Cerebral palsy means a definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements.

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

Congenital heart disease

Congenital heart disease means a definite diagnosis of at least one of the covered heart conditions described below. It also means the specific conditions described below for which open heart surgery is performed to correct the condition.

Covered heart conditions:

- coarctation of the aorta,
- Ebstein's anomaly,
- Eisenmenger syndrome,
- Tetralogy of Fallot,
- transposition of the great vessels.

The diagnosis of the heart condition must be:

- made by a specialist physician; and,
- supported by cardiac imaging acceptable to us.

The covered person must survive for 30 days following the date of diagnosis.

Covered heart conditions if open heart surgery is performed (these heart conditions are covered only if open heart surgery is performed to correct at least one of them):

- aortic stenosis,

- atrial septal defect,
- discrete subvalvular aortic stenosis,
- pulmonary stenosis,
- ventricular septal defect.

Procedures not covered by this definition are:

- percutaneous atrial septal defect closure;
- trans-catheter procedures which include balloon valvuloplasty.

The diagnosis of the heart condition must be made and the surgery must be recommended and performed:

- by a specialist physician; and,
- supported by cardiac imaging acceptable to us.

The covered person must survive for 30 days following the date of surgery.

Cystic fibrosis Cystic fibrosis means a definite diagnosis of cystic fibrosis where the covered person has chronic lung disease and pancreatic insufficiency.

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

Down's syndrome Down's syndrome means a definitive diagnosis of Down's syndrome supported by chromosomal evidence of Trisomy 21.

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

Muscular dystrophy

Muscular dystrophy means a definite diagnosis of muscular dystrophy where the covered person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

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

Type 1 diabetes mellitus

Type 1 diabetes mellitus means a definite diagnosis where the covered person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

What is not covered

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

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

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

Child moratorium period exclusion

Any child of you or your spouse will be excluded from Critical Illness coverage if:

- that child was born within the 90 day period prior to the date you obtain Child Critical Illness coverage; or,
- that child is born on or within 10 months after the date you obtain

Critical Illness coverage for your existing children,

and, before or within 90 days after that child's birth:

- that child is diagnosed with any covered condition; or,
- that child has any signs, symptoms or investigations that lead to a diagnosis of a covered condition within 5 years of the child's birth.

Pre-existing conditions

For any coverage that did not require proof of good health, no benefits are payable for any covered condition that occurs within 12 months of the effective date of the covered person's coverage, and that resulted from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person had symptoms, consulted a physician or other health care practitioner or was provided any health-related care, advice or treatment, or that a reasonably prudent person with such injury, sickness or medical condition would have consulted a physician or any other health care practitioner, during the 12 months prior to the effective date of the covered person's coverage. If coverage ends but the person is covered again under this benefit, we will use the latest date the person's coverage began when applying the above limitation. This exclusion does not apply where the *Child moratorium period exclusion* applies or to any child of the employee or the employee's spouse who is born or adopted later than 10 months after the date the employee becomes covered for Child Critical Illness.

Portability

If your Critical Illness coverage ends for any reason other than your request, you may apply to transfer the group Critical Illness coverage to a group critical illness policy set up for that purpose by Sun Life without providing proof of good health.

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 a group critical illness policy set up for that purpose by Sun Life without providing proof of good health. This is not available for dependent children.

The request must be made within 31 days of the end of the Critical Illness coverage.

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

When and how to make a claim

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

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

Best Doctors

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

If you or your spouse are covered for Critical Illness, you, your spouse and your children have access to Best Doctors. If only your children are covered for Critical Illness, no access to Best Doctors is provided.

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition, even if it is not a covered condition under this Critical Illness benefit. To use this service, please call Best Doctors at 1-877-419-BEST (2378). For a complete description of their services, including information on limitations and exclusions, please refer to your brochure entitled *my wellness, my plan – Best Doctors services*.

Liability and responsibility of Sun Life

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

Sun Life cannot guarantee the availability of Best Doctors services.

Life Coverage

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Optional 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 child dies, Sun Life will pay you the benefit for that dependent.

For your spouse’s optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor’s behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. 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, while sane or insane. 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.

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

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

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

Converting Life coverage

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

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

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends due to the termination of your Life coverage, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good health.

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

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

When and how to make a claim

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

Salary Continuance Program

General description

The Salary Continuance program is provided by your employer. Sun Life may provide services to assist your employer in assessing and managing your absence based on assessment guidelines approved by your employer.

Salary Continuance provides for the continuation of a portion of your salary if you become totally disabled. You qualify for Salary Continuance if you present proof acceptable to Sun Life that:

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

For the purposes of the Salary Continuance program, you will be considered totally disabled while you are continuously unable due to injury or illness to do the essential duties of your own occupation.

Your Salary Continuance payment will be based on the terms of the Salary Continuance program in effect on the date you became totally disabled.

When Salary Continuance payments begin

If you become totally disabled because of an accident or illness, you will be eligible for Salary Continuance payments after 5 business days of uninterrupted total disability.

Salary Continuance payment are paid only for the scheduled business days that you are totally disabled. If you are totally disabled for part of any week, your employer will pay 1/5 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 eligibility under the Salary Continuance program continues during this time, you will be eligible for Salary Continuance payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for at least 5

uninterrupted business days and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

Interrupted periods of disability

If you had a total disability for which your employer paid Salary Continuance to you and total disability occurs again due to the same or related causes, your employer 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 eligible under the Salary Continuance program when the total disability reoccurs.

Salary Continuance payments will be based on the terms of the Salary Continuance program as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum payment period.

What your employer will pay

Here is how your employer calculates your Salary Continuance payments. All references to income in this provision are to the gross amounts before any deductions.

Step 1: As indicated below:

Number of weeks	Amount payable	Paid through
5 uninterrupted business day elimination period	5 sick days applied	Regular payroll method
Week 1 to week 4 (upon approval)	100% of basic earnings	Regular payroll method
Week 5 to week 26 (upon approval)	70% of basic earnings	Regular payroll method
Week 27 and onward (upon approval)	LTD payments	Health Benefits Carrier (Sun Life)

If your Salary Continuance payment is less than the benefit that would be payable under the Employment Insurance Act, your basic earnings will be increased by 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: Your employer subtracts 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, including a multiple-employer group plan.
- under the Québec Parental Insurance Plan.

After the first 26 weeks of total disability, when the maximum payment period is more than 26 weeks, your employer also subtracts any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases that occur after Salary Continuance payments begin.
- under a retirement or pension plan funded in whole or in part by your 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 Salary Continuance payment. However, if the amount calculated under Step 2, plus the above sources of income, exceeds 85% of your pre-disability basic earnings, your Salary Continuance payment is reduced by the excess.

If you are eligible for any of the income amounts above and do not apply for them, your employer will still consider them as part of your income. Your employer can estimate those benefits and use those amounts when calculating your payments.

If you receive any of the income amounts above in a lump sum, your employer will determine the equivalent compensation this represents on

a weekly basis using generally accepted accounting principles.

Your employer 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.

Your employer has the right to adjust your Salary Continuance 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.

Your employer 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.

Salary Continuance 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 5 uninterrupted business days, provided your eligibility under the Salary Continuance program has been continued.

Rehabilitation program

You may be required to participate in a rehabilitation program if recommended by Sun Life.

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

Your employer is under no obligation to approve or continue a rehabilitation program for you . Your employer will consider such factors as financial considerations and its opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive Salary Continuance payments plus income from other sources. However, if during any week your total income is more than 100% of your basic earnings when your disability began, your Salary Continuance payment will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled.

When payments end

Your Salary Continuance payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the end of a maximum payment period of 119 days.
- the date you retire on pension.
- the date you die.

When eligibility ends

Your eligibility under the Salary Continuance program will end on the day you retire.

Payments after the Salary Continuance program ends

If the Salary Continuance program terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the program were still in effect.

What is not covered

Your employer will not pay Salary Continuance for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by your employer .
- you are not participating in an approved rehabilitation program, if

recommended by Sun Life and approved by your employer.

- 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 payment period.
- you are absent from Canada longer than 4 weeks due to any reason, unless your employer agrees in writing in advance to pay Salary Continuance during the period.
- you are serving a prison sentence or are confined in a similar institution.

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

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

When and how to initiate a request for Salary Continuance

To initiate a request for Salary Continuance, you must request claim forms from your employer. The forms should be completed and sent to Sun Life as soon as possible to keep payment wait time to a minimum.

Sun Life will perform a review and assessment based on the information provided and will notify you and your employer as to whether or not your absence is supported based on the defined absence Assessment Guidelines.

If your absence is supported, Sun Life will provide ongoing case management, gather additional information, including additional medical information, if appropriate, and communicate regularly with you, your

employer and the treatment providers to assist you in returning to work.

Respecting your privacy

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

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

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