your group benefits

Contract Number: 103435 and 152435
Effective: January 1, 2024
Issued: September 29, 2023

Active Bargaining Unit

ICBC

Sun Life Financial

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How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-866-896-6976.

For faster service, have your **group contract number** and **member ID** ready to enter into our automated telephone system.

Plan Member Services

Download the my Sun Life Mobile App!

- Free from the Apple App Store or Google Play, anytime
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

Access to mysunlife website

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

Prior Authorization Program

For the form:

- visit our website at www.mysunlife.ca/priorauthorization
- call a Sun Life Financial Customer Care representative toll-free at 1-866-896-6976

For the list of drugs:

- visit our website at www.mysunlife.ca/priorauthorization

Your Drug Card

Provided by your employer or online at www.mysunlife.ca.

Note: If you have refused Extended Health Care coverage under this plan, this drug card does not apply to you.

Your Travel Card

Provided by your employer or online at www.mysunlife.ca.

Note: If you have refused Extended Health Care coverage under this plan, this travel card does not apply to you.

Need to contact Sun Life’s Emergency Travel Assistance provider?

In the USA and Canada, call: 1-800-511-4610.

All other inquiries

Call 1-877-SUN-LIFE (1-877-786-5433).

Benefit Summary

The information contained in this summary applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Accidental Death & Dismemberment benefit described later in this booklet is not insured or administered by Sun Life.

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Waiting period	The waiting period is: • The period ending on the last day of the month in which you have completed 3 months of continuous employment for Dental Care • The period ending on the last day of the month in which your employment began for Extended Health Care. However, if your employment began on the first day of the month, there is no waiting period. • None for all other benefits. Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care - Contract Number 152435

Benefit year	January 1 to December 31
Deductible	Individual – $25 per benefit year Family – $25 per benefit year
Reimbursement level	For all eligible expenses combined, the reimbursement percentages described below apply to the first $1,000 of paid expenses per family per benefit year. Thereafter, any eligible expenses in excess of $1,000 per family per benefit year, other than referred services, are paid at 100%.
Drug card plan	Included
Prescription drugs	80% after the deductible Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*

	We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist: • drugs that legally require a prescription • life-sustaining drugs that may not legally require a prescription • injectable drugs and vitamins • compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN • diabetic supplies • drugs for the treatment of infertility, up to a lifetime maximum of $15,000 per person • vaccines • intrauterine devices (IUDs) and diaphragms • varicose vein injections • anti-obesity drugs There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.
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.
Dispensing fee	Eligible expenses for the dispensing fee are limited to the provincial average, for each prescription or refill
Drug substitution limit	We will not cover charges above the lowest priced equivalent drug unless the doctor specifies in writing that no substitution for the prescribed drug may be made
In-province hospital	80%, after the deductible, of the difference between the cost of a ward and a private room
Out-of-province emergency services	100% without the deductible Emergency Travel Assistance included Time limit – None Lifetime maximum of $1,000,000 per person for out-of-Canada emergency and referred services
Out-of-province referred services	80% without the deductible
Medical services and equipment	80% after the deductible
Gender affirmation procedures	80%, after the deductible, up to a maximum of $10,000 per person per benefit year but no more than $50,000 in a person's lifetime
Paramedical services	80%, after the deductible, up to a combined maximum of $2,500 per person per benefit year for the qualified paramedical practitioners listed below: • psychologists, social workers, clinical counsellors and psychotherapists 80%, after the deductible, up to a combined maximum of $1,500 per person per benefit year for all the qualified paramedical practitioners listed below: • massage therapists • speech therapists • physiotherapists • naturopaths

	• acupuncturists • osteopaths or osteopathic practitioners. X-ray examinations are not covered. • chiropractors, including x-ray examinations. However, a separate maximum of $50 per person in a benefit year applies to x-ray examinations. • podiatrists or chiropodists. X-ray examinations are not covered. • athletic therapists
Vision care	Contact lenses, eyeglasses, laser eye correction surgery – 80%, after the deductible, up to a maximum of $500 per person over 2 benefit years Services of an ophthalmologist or licensed optometrist – 80%, after the deductible, up to a maximum of 1 examination per person in any 24 month period
Maximum benefit	Lifetime maximum benefit for all expenses, other than out-of-province emergency and referred expenses – $350,000 per person
Termination	When you retire
At retirement	For more information about coverage after retirement, please contact your employer

Dental Care - Contract Number 152435

Benefit year	January 1 to December 31
Deductible	None
Fee guide	The current fee guide in the province where the employee lives, regardless of where the treatment is received If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that specialty, then the fee guide approved by the provincial Dental Association for that specialist will be used
Reimbursement level	
Preventive procedures	100%
Basic procedures	100%
Major procedures	70%
Orthodontic procedures	50%
Maximum benefit	
Benefit year maximum	Unlimited A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime maximum	Orthodontic procedures – $5,000 per person
Termination	When you retire

Critical Illness - Contract Number 103435 (including Teladoc Medical Experts services)

Employee Optional Critical Illness

Amount	You can choose coverage in units of $10,000 Maximum – $250,000 Minimum – $20,000
Proof of good health	Approval required on the initial optional amount of coverage, except for the first $50,000 if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, whichever is earlier. In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.

Spouse Optional Critical Illness

Amount	You can choose coverage in units of $10,000 Maximum – $250,000 Minimum – $20,000
Proof of good health	Approval required on the initial optional amount of coverage, except for the first $20,000 if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier. 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.

Child Optional Critical Illness

Amount	You can choose coverage in units of $5,000 per child Maximum – $20,000
Termination	When you retire or reach age 70, whichever is earlier. 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.

Life - Contract Number 103435

Employee Basic Life

Amount	Your annual basic earnings rounded to the next higher $1,000 times 2 Maximum – $2,000,000

Proof of good health	Approval required for coverage in excess of $1,000,000, and any increase in that coverage of 25% or more or $25,000, whichever is greater
Termination	When you retire

Employee Optional Life

Amount	You can choose coverage in units of $25,000 Maximum – $900,000
Overall maximum	$2,000,000 for basic and optional combined
Proof of good health	Approval required on the initial optional amount of coverage, except for the first $150,000 if enrolment is made within 31 days of the eligibility date, and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, whichever is earlier

Basic Dependent Life

Amount	Spouse – $10,000 Child – $5,000
Termination	When you retire

Spouse Optional Life

Amount	You can choose coverage in units of $25,000 Maximum – $500,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier

Child Optional Life

Amount	You can choose coverage in units of $5,000 per child Maximum – $25,000
Termination	When you retire or reach age 70, whichever is earlier

Making Claims

There are time limits for making claims. You can find more on these time limits in the following chart. **If you fail to meet these time limits, you may not be entitled to some or all benefit payments**.

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Ask your employer for the form to complete, or get the form on our website.	Up to the earlier of the following dates: • 365 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Extended Health Care coverage.
Emergency Travel Assistance	Contact Sun Life's Emergency Travel Assistance provider to notify them that a medical emergency exists.	**Having expenses reimbursed:** To have services or supplies reimbursed that either you or another covered person have paid for, proof of the expenses must be provided to us within 30 days of the person's return to the province where the person lives. Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.

Type of claim	Starting the claims process	Limits and special instructions
Dental Care	Ask your employer for the form to complete, or get the form on our website. The dentist will have to complete a section of the form.	Up to the earlier of the following dates: • 365 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Dental Care coverage. If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information. For orthodontic procedures, a treatment plan will need to be submitted to us.
Critical Illness coverage	Contact us to get the proper claim form.	**Initial contact with Sun Life:** Within 30 days after the date of diagnosis or surgery. **Proof of claim:** Up to 90 days after the date of diagnosis or surgery. Failure to contact us or furnish proof of claim within the above time limits does not invalidate the claim if the contact is made or the 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 contact us or furnish proof within the above time limits.
Life coverage	Ask your employer to provide the claim forms.	**If the claim is a result of a death:** We must receive the claim form as soon as possible after the death occurred. **For coverage during total disability:** We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

General Information

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Accidental Death & Dismemberment benefit described later in this booklet is not insured or administered by Sun Life.

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

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

For administrative purposes, number 106386 will be used for the Critical Illness benefit under this contract.

Have questions? Need more information about your group benefits? Talk to your employer.

Your group benefits	The contract holder, Insurance Corporation of British Columbia, self-insures the following benefits: • Extended Health Care • Emergency Travel Assistance • Dental Care This means Insurance Corporation of British Columbia has the sole legal and financial liability for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.
Who is eligible to receive benefits?	To be eligible for group benefits, you must reside in Canada and meet all the following conditions: • you are a permanent employee working in Canada. • you are actively working for your employer. • you have completed the waiting period indicated in the Benefit Summary. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent. 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 • residing in Canada or the United States. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage. • under any other formal union recognized by law. • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least 12 months. 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 under age 21 and do not have a spouse. A child who is a full-time student is also considered an eligible dependent as long as the child is attending an educational institution recognized under the Income Tax Act (Canada) at least 10 hours per week. **If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**
How to enrol	*For you* – You must provide the proper enrolment information to Sun Life through your employer. *For a dependent* – You must ask for dependent coverage. If you or your dependents already have similar Extended Health Care or Dental Care coverage under this or another plan – You may refuse this coverage under this plan. If the other coverage ends at a later date, you can enrol for coverage under this plan then. You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health. • Employee Basic Life • Employee Optional Life • Spouse Optional Life • Employee Optional Critical Illness • Spouse Optional Critical Illness
When coverage begins	Your coverage begins **on the later of** the following dates: • the date you become eligible 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 you first have a dependent.
	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.
Changes affecting your 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 an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

	For Critical Illness coverage, to understand the impact on coverage when new covered conditions are added to this plan, refer to the *Critical Illness* section.
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	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-866-896-6976.
When coverage ends	As an employee, your coverage will end on the earlier of the following dates: • the date your employment ends for any reason other than retirement on pension. • the date you are no longer actively working. • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends. A dependent's coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage. The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

If you die while covered by this plan

Coverage for your dependents will continue, without anyone paying further premiums, until **the earlier of** the following dates:

- the last day of the month following the month in which you die for Extended Health Care and Dental Care.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

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

For dependent life, coverage will not continue after you die, however, if your spouse dies within 31 days of you, the benefit will be paid to your estate.

The continuation of coverage does not apply to Spouse and Child Optional Life and Optional Critical Illness.

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

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

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total eligible expenses.

When you have more than one plan, insurance industry standards determine which plan you should claim expenses from first.

Please send in claims for you and your spouse in the following order:

- First, send in the claim to the plan where the person is covered as an employee. If the person is an employee under two plans, send the claim to the different plans in the following order:
  - to the plan where the person is covered as an active full-time employee.
  - then, to the plan where they are covered as an active part-time employee.
  - then, to the plan where they are covered as a retiree.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

- First send in the claim to the plan where the child is covered as an employee.
- Then, to the plan where they are covered under a student health or dental plan through their educational institution.
- Then, to the plan of whichever parent has 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.

When you send us a claim, you must tell us about all other equivalent coverage that you or your dependents have.

Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefits.

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits appear in the benefit sections.

Accident	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
Basic earnings	Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.
Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Illness	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.
Retiree	A person who was an Employee immediately prior to his retirement.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Extended Health Care

Plan administrator

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

General description of the coverage

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

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

Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required for treating an illness according to Canadian medical standards.

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

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

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

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Deductible, reimbursement level and maximum benefit	The deductible is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the reimbursement level and maximum benefit under this plan. **For each type of service listed below, the deductible and the reimbursement level are indicated in the Benefit Summary. The maximum benefit for all expenses combined is also indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period as ordered by a doctor.
What is not covered	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. • proteins and food or dietary supplements. • hair growth stimulants. • products to help you quit smoking. • drugs for the treatment of sexual dysfunction. • drugs that are used for cosmetic purposes. • natural health products, whether or not they have a Natural Product Number (NPN). • drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
Drug evaluation	The following drugs will be evaluated and must be approved by us to be eligible for coverage: • drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017. • drugs covered under this plan and subject to a significant increase in cost. Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval. We will assess the eligibility of the drug based on factors such as: • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • availability of other drugs treating the same or similar condition(s). • plan sustainability.
Prior authorization program	The prior authorization (PA) program applies to a limited number of drugs, where you must get approval in advance for coverage under the program. In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form. You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as: • Health Canada Product Monograph. • recognized clinical guidelines. • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • your response to preferred drug therapy. If not, your claim will be declined. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.

Reference Drug Program	The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will: • group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*). • determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness. • limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*). • apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category*. For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as: • clinical support for switching to the *Reference Drug*. • expected duration of treatment. • provincial programs. Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*. When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

Hospital expenses in your province

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

Expenses out of your province

Expenses out of your province	We will cover emergency services while you are outside the province where you live. We will also cover referred services. **For both emergency services and referred services, the reimbursement level is indicated in the Benefit Summary.** For both emergency services and referred services, we will cover the cost of: • a private hospital room • other hospital services provided outside of Canada • out-patient services in a hospital • the services of a doctor
Emergency services	*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 treatment program that existed before they left their home province. *Emergency* means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. **Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away. Sun Life's ETA provider must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them. **If** Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency. In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. An emergency ends when Sun Life's ETA provider, based on available medical evidence, deems you medically stable to return to the province where you live.
Emergency services excluded from coverage	Any expenses related to the following emergency services are not covered: • services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services. • services relating to an illness or injury which caused the emergency, after such emergency ends. • continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Sun Life's ETA provider, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return. • services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services. • where the trip was taken to obtain medical services for an illness or injury, services

	related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.
Referred services	*Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services. All referred services must be obtained in Canada, if available, regardless of any waiting lists. However, if referred services are not available in Canada, they may be obtained outside of Canada.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor • ultrasounds • medical imaging services, including MRIs and CT scans	For all medical imaging services combined, $1,000 per person per benefit year

Covered expenses	Details	Payment limits
Dental services following an accident	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 You must receive these services within 12 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the employee lives
Contact lenses or intraocular lenses	After cataract surgery	One lens per eye, per lifetime
Wigs	After chemotherapy	$500 per person, per lifetime
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs	For wheelchairs, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses or crutches		
Splints or braces	Must be prescribed by a doctor	
Breast prostheses	Required as a result of surgery	
Surgical brassieres	Required as a result of surgery	$150 per person per benefit year
Artificial limbs and eyes		
Stump socks		$200 per person per benefit year
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	$200 per person per benefit year for a person under age 21 and $400 per person per benefit year for any other person
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair per person per benefit year
Prefabricated orthopaedic shoes or modifications to prefabricated orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	$200 per person per benefit year for a person under age 21 and $400 per person per benefit year for any other person
Hearing aids		$1,000 per person over 2 benefit years for a person under age 21 and $1,000 per person over 5 benefit years for any other person Repairs are included in this maximum
Oxygen		

Covered expenses	Details	Payment limits
Blood glucose monitors		$700 per person, per lifetime
Continuous Glucose Monitor (CGM) receivers, transmitters or sensors	Only for persons diagnosed with Type 1 or Type 2 diabetes You must provide us with a doctor's note confirming the diagnosis	Combined maximum of $4,000 per person per benefit year
Colostomy supplies		
Incontinence supplies such as diapers, pads and disposable briefs	Required as a result of an illness	

Gender affirmation procedures

Gender affirmation procedures	We will cover, up to the reimbursement level indicated in the Benefit Summary, the costs of the following gender affirmation procedures, provided you meet the *Eligibility requirements* set out below. **Eligible procedures:** • breast augmentation/augmentation mammoplasty. • thyroid chondroplasty. • laryngoplasty. • permanent hair removal (laser or electrolysis) for pre-surgical areas, or for excessive facial or body hair. • brow bone reduction/construction. • jaw bone reduction/reshaping/contouring. • rhinoplasty, blepharoplasty and rhytidectomy. • liposuction of the waist. • gluteal augmentation (lipofilling or implants). • hairline reconstruction to correct a receding hairline. • hysterectomy. • vaginectomy. • salpingo-oophorectomy. • chest contouring/chest masculinization, including liposuction/lipofilling done to provide additional contouring. • implantation of penile and/or testicular prostheses. • chin and cheek augmentation. • pectoral implants.
	We reserve the right to modify the above list of eligible expenses in the event there is a change in the list of procedures covered by any of the gender affirmation programs in a province or territory.

Eligibility requirements	• You must be under the care of a doctor for gender affirming care. • You must be at least 18 years old and must have been diagnosed with gender dysphoria by a doctor. • Prior approval is required. You and your doctor must complete the *Gender Affirmation application form,* and submit it to us. • All procedures must be considered medically necessary by your doctor. • All procedures must be performed in Canada. • Only expenses incurred after your effective date for coverage under this benefit provision, and while this benefit provision is in force, will be eligible for reimbursement. Before incurring an expense, you must call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212 to obtain the *Gender Affirmation application form*. We will assess all procedures based on the terms of this plan. We reserve the right to request details of procedures performed. You may incur other expenses, such as drugs or paramedical services, related to gender affirming care. To determine if these other expenses are eligible under this plan, and any applicable benefit maximum, please refer to the *Prescription drugs*, *Paramedical services* or other applicable provisions of this Extended Health Care benefit.
What is not covered	We will not pay for the costs of: • procedures payable or available under the medicare plan in your place of residence, regardless of whether you have applied to, or been accepted into, the gender affirmation program. • travel or accommodations expenses. • reversal of gender affirmation procedures. • sperm preservation or cryopreservation of fertilized embryos. • procedures related to fertility problems caused by gender affirming treatment and/or surgical care.

Covered expenses	Details	Payment limits
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary

Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Qualified paramedical practitioners must:

- belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us,
- be licensed or registered, as required by the applicable provincial regulatory body,
- have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered,
- maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association,
- produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and
- not engage in administrative practices unacceptable to us.

This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or

Covered expenses	Details	Payment limits
supplies rendered at that clinic are eligible for reimbursement under this plan.		
Vision care		
Contact lenses, eyeglasses or laser eye correction surgery and services of an ophthalmologist or licensed optometrist	An ophthalmologist or licensed optometrist must have prescribed contact lenses or eyeglasses You must have received the above from an ophthalmologist, licensed optometrist or optician We will only cover laser eye correction surgery that an ophthalmologist has performed	Up to the reimbursement level indicated in the Benefit Summary We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

Payments after coverage ends

If you are totally disabled, as defined in the contract, 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.

If the Extended Health Care benefit ends, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

- the accident occurred while you were covered, and
- you have the procedure 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 *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that we consider ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- 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.

Integrating this plan 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 the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

Emergency Travel Assistance

Plan administrator

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

General description of the coverage

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

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

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.

The emergency services excluded from coverage, and all other conditions including maximums, limitations and exclusions that apply to your Extended Health Care coverage also apply to Medi-Passport.

Bring your Travel card with you! There you will find telephone numbers and the information you'll need to confirm your coverage and get help.

Getting help	**Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away.
	If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card. Sun Life's ETA provider may arrange for:
On the spot medical assistance	Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities. As soon as Sun Life's ETA provider is notified that you have a medical emergency, its staff, or a physician designated by Sun Life's ETA provider, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Sun Life's ETA provider will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

	Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel. Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.
Transportation home or to a different medical facility	Sun Life's ETA provider may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation. Sun Life or Sun Life's ETA provider, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.
Meals and accommodations expenses	If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Sun Life's ETA provider will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days. Sun Life's ETA provider will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Sun Life's ETA provider, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.
Travel expenses home if stranded	Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live: • for you if, due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated (sent home); or • **for a child** if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified person to go home with the child as their attendant. We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.
Travel expenses of family members	Sun Life's ETA provider will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.

Returning you home (repatriation)	If you die while out of the province where you live, Sun Life's ETA provider will pay up to $5,000 to do the following: • arrange for all necessary government authorizations. • arrange for the return of your remains in an approved container.
Returning your vehicle	Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 to return 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 doing so.
Lost luggage or documents	If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Sun Life's ETA provider will direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
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.
Reimbursement of expenses	If you obtain confirmation from Sun Life's ETA provider that you are covered and a medical emergency exists, Sun Life will reimburse you for services and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Sun Life's ETA provider. Sun Life's ETA provider's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-866-896-6976. Sun Life's ETA provider will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Sun Life's ETA provider before your claim can be processed.
Coordination of coverage	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.
Your responsibility for advances	You will have to reimburse Sun Life for any of the following amounts advanced by Sun Life's ETA provider: • any amounts which are or will be reimbursed to you by your provincial medicare plan. • that portion of any amount which exceeds the maximum amount of your coverage under this plan. • amounts paid for services or supplies not covered by this plan. • amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you. Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received.

Limits on Emergency Travel Assistance coverage	There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before you leave on your trip. Sun Life's ETA provider reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: • a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or an act of God. • the refusal of authorities in the country to permit Sun Life's ETA provider to fully provide service to the best of its ability during any such occurrence.
Liability of Sun Life or Sun Life's ETA provider	Neither Sun Life nor Sun Life's ETA provider will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Care

Plan administrator

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

General description of the coverage

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

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

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

For each dental procedure, we will only cover **reasonable expenses**. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. 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.

We will base payments on the fee guide at the time the person receives the treatment.

To decide what part of a procedure we will pay for:

- we will first find out if you could have had alternate, or other, dental procedures.
- we confirm that these alternate procedures are part of usual and accepted dental work and produced a similar result to the procedure that the dentist performed.

We will only pay the reasonable cost of the least expensive alternate procedure.

If you receive any temporary dental service	It will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the reasonable and customary charge for the final dental service.
Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. The benefit year is indicated in the Benefit Summary. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed, except for orthodontic procedures where an expense is considered incurred following the first appointment and submission of the treatment plan. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary**.
Maximum benefit	Maximums are indicated in the Benefit Summary.

Getting an estimate before you have certain procedures	For any major treatment or any procedure that will cost more than $500, we suggest that you send us an estimate before the work is done. Here's what to expect: • you will 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.

Your dental services at a glance

Covered expenses	Details / Payment limits
Preventive dental procedures – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.	
Oral examinations	• 1 complete examination every 24 months. • 1 recall examination every 6 months. • emergency or specific examinations.
X-rays	• 1 complete series of x-rays or 1 panorex every 24 months. • 1 set of bitewing x-rays every 6 months. • x-rays to diagnose a symptom or examine progress of a certain course of treatment.
Other services	• required consultations between two dentists. • polishing (cleaning of teeth) and topical fluoride treatment once every 6 months. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth. • anaesthesia in conjunction with a dental procedure covered under this plan. • providing space maintainers for missing primary teeth. • pit and fissure sealants. • oral hygiene instruction up to a lifetime maximum of 2 sessions.
Fillings	• amalgam (silver) and composite or acrylic (white), or equivalent.
Basic restorations	• prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.
Basic dental procedures – Your dental benefits include the following procedures used to treat basic dental problems.	
Extraction of teeth	• removing teeth, except impacted teeth (*Preventive dental procedures*).
Endodontics	• root canal therapy and root canal fillings, and treatment of disease of the pulp tissue. Root canal therapy and root canal fillings are limited to one initial treatment and one re-treatment per tooth per lifetime. Retreatment must be incurred more than 12 months after the initial treatment.

Periodontics	• treating disease of the gum and other supporting tissue, including management of oral manifestations, oral mucosal disorders, mucocutaneous disorders and diseases of localized mucosal conditions, but excluding treatment for temporomandibular joint dysfunction. • scaling, up to a combined maximum of 14 units of 15 minutes per benefit year. • occlusal equilibration, up to a maximum of 8 units of 15 minutes per benefit year.
Oral surgery	• surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).
Repair of dentures	• 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.	
Major restorations	• inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Preventive dental procedures*).
Repair of bridges	• repair of bridges.
Prosthodontics	Construction and insertion of bridges or standard dentures, limited to teeth extracted while a person is covered under this provision, until you have been employed for 2 consecutive years. We do not consider charges for a replacement bridge or replacement standard denture an eligible expense during the 5 year period after a previous bridge or standard denture is constructed or inserted**, unless either 1. or 2. below is true:** 1. it is needed to replace a bridge or standard denture which has caused temporomandibular joint (TMJ) disturbances and which cannot be economically modified to correct the condition. 2. it is needed to replace a transitional denture which was inserted shortly after teeth were extracted, where the dentist cannot economically get it to the final shape needed.
Implants	• implants, excluding surgery charges, subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant. For the implant related crown or prosthesis, Sun Life will pay the benefit that would have been payable under this plan for a non implant related bridge or denture.
Orthodontic procedures – Your dental benefits include the following procedures used to treat misaligned or crooked teeth.	
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.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

Payments after coverage ends

If the Dental Care benefit ends, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

- the accident occurred while you were covered, and
- you have the procedure within 6 months after the date of the accident.

What is not covered

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

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

We will not pay for:

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

Critical Illness

Insurer

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

General description of the coverage

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

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

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

What we will pay	We will pay the Critical Illness benefit if, after the effective date of coverage, and while coverage is in force, you or your dependent (spouse or child) have a diagnosis of a covered condition, or you or your dependent have surgery for a covered condition, subject to the survival period. Claims will be assessed based on the Critical Illness provisions in effect on the date of diagnosis or surgery. The Critical Illness benefit is payable only on the first covered condition for which a diagnosis is effective, or surgery is performed, and the person's coverage then terminates. Such person may not become covered again under this benefit. We reserve the right to require examination of the covered person and confirmation of any diagnosis of or surgery for any covered condition, by a medical practitioner appointed by us in order for any Critical Illness benefit to become payable.
Diagnosis	Diagnosis means a written diagnosis by a physician or specialist physician, licensed and practicing in Canada, of the covered condition. Any diagnosis must be made while coverage is in force and will be effective as of the date it is established by the physician or specialist physician, as supported by the covered person's medical records. Any diagnosis of a covered condition that was made prior to the effective date of coverage will not be covered.
Life support	Life support means the covered person is under the regular care of a licensed physician or specialist physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.
Physician	Physician means a legally and professionally qualified medical practitioner practicing in Canada. The physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Specialist physician	Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a speciality examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.
Surgery	Surgery means a medical operation performed on the covered person and recommended by a physician or specialist physician, licensed and practicing in Canada.
Survival period	Survival period means the period starting on the date of diagnosis of the critical condition and ending 30 days following the date of diagnosis of the critical condition, unless a covered condition described below expressly modifies this definition. The survival period does not include the number of days on life support. The covered person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.
Who we will pay	The Critical Illness benefit is payable to you or, in the event of your death, to your estate.
Changes in coverage	Changes in the amount of coverage or covered conditions may occur as the result of an employment status change or a change in plan design.
Changes in the amount of coverage	If you are not actively working or a dependent is hospitalized (other than a newborn child) on the date a change occurs, refer to *Changes affecting your coverage* in the *General Information* section to understand the effective date of any change to the amount of Critical Illness coverage. The *Pre-existing conditions* provision under *What is not covered* will apply to increased amounts of coverage as described in that provision.
Other changes	If new Critical Illness conditions are added to this plan, the new Critical Illness conditions will only apply to: • employees who are actively working; • dependents who are not hospitalized (other than newborn children); and • persons already having Critical Illness coverage on the date that the change occurs. The effective date of coverage for the new covered conditions is the date of the change to the plan. If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions. If a dependent is hospitalized when the change occurs (other than a newborn child), the change will take effect when the dependent is discharged and resumes normal activities and such date will be the dependent's effective date of coverage for the new covered conditions. In all instances, we will: • apply the effective date of coverage to determine a person's eligibility for a Critical Illness benefit payment; and • apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where:

	• proof of good health was previously required for a person's coverage; or • the *Child moratorium period exclusion* previously applied or the child was born or adopted later than 10 months after the date the employee became covered for Child Critical Illness. If the definition of a Critical Illness condition is changed, we will adjudicate any claim for a Critical Illness benefit based on the definition of that Critical Illness condition in effect on the date of the diagnosis or surgery, regardless of whether you were actively working or your dependent was hospitalized on the date of the change. In the event of a change of carrier, the following rules apply to any person who was covered under the previous group contract on the date immediately preceding the effective date of coverage under this plan: • the new plan, including coverage for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all employees and dependents on the effective date of this plan, regardless of whether the employee is actively working or the dependent is hospitalized on such date; • for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of coverage is the effective date of this plan; and • for Critical Illness conditions under this plan which were also covered under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of coverage is the date the person most recently became covered under the previous carrier's plan. If a person received a Critical Illness benefit payment under the previous carrier's plan, then such person will not be covered under this plan for that Critical Illness condition for which a benefit payment was already made. Sun Life is not responsible for any claim where the date of diagnosis or surgery, as applicable, is before the effective date of this plan.
Covered conditions for employees, spouses and children	We provide coverage for any illness, disorder or surgery that is defined below:
Aortic surgery	Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery. Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
Aplastic anemia	Aplastic anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: • marrow stimulating agents; • immunosuppressive agents; or • bone marrow transplantation.

	The diagnosis of aplastic anemia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Bacterial meningitis	Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis. Exclusion: No benefit will be payable under this condition for viral meningitis.
Benign brain tumour	Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis. Exclusions: No benefit will be payable under this condition for pituitary adenomas less than 10 mm. No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage. Moratorium Period Exclusion: If, within 90 days following the later of: • the date a person enrols for any amount of coverage; or • the effective date of such amount of coverage, the covered person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this coverage), regardless of when the diagnosis is made; or • a diagnosis of benign brain tumour (covered or excluded under this coverage), no benefit will be payable for benign brain tumour for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for benign brain tumour for those additional amounts. All other coverage remains in force. The information described above must be reported to 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 (life-threatening)	Cancer (life-threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of cancer must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis. Exclusions: No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage. No benefit will be payable under this condition for the following: • lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta; • malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis; • any non-melanoma skin cancer, without lymph node or distant metastasis; • prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; • papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis; • chronic lymphocytic leukemia classified less than Rai stage 1; or • malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2. Moratorium Period Exclusion: If, within 90 days following the later of: • the date a person enrols for any amount of coverage; or • the effective date of such amount of coverage, the covered person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; or • a diagnosis of cancer (covered or excluded under this coverage), no benefit will be payable for cancer for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for cancer for those additional amounts. All other coverage remains in force. The information described above must be reported to 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. For the purposes of this benefit, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. For the purposes of this benefit, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.
Coma	Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of coma must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis. Exclusions: No benefit will be payable under this condition for: • a medically induced coma; • a coma which results directly from alcohol or drug use; or, • a diagnosis of brain death.
Coronary artery bypass surgery	Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery. Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
Deafness	Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Dementia, including Alzheimer's disease	Dementia, including Alzheimer's disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function: • aphasia (a disorder of speech); • apraxia (difficulty performing familiar tasks); • agnosia (difficulty recognizing objects); or • disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour), which is affecting daily life.

	The covered person must exhibit: • dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and • evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis. Exclusion: No benefit will be payable under this condition for affective or schizophrenic disorders or delirium. For purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.
Heart attack	Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: • heart attack symptoms; • new electrocardiogram (ECG) changes consistent with a heart attack; or • development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. The diagnosis of heart attack must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis. Exclusions: No benefit will be payable under this condition for: • elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or • ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.
Heart valve replacement or repair	Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery. Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney failure	Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Loss of independent existence	Loss of independent existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery. Activities of daily living are: • Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices; • Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices; • Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices; • Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained; • Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and • Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices. The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.
Loss of limbs	Loss of limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Loss of speech	Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied. Exclusion: No benefit will be payable under this condition for any psychiatric related causes.
Major organ failure on waiting list	Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the covered person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the covered person's enrolment in the transplant centre.

	The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Major organ transplant	Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the covered person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of their transplant.
Motor neuron disease	Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Multiple sclerosis	Multiple sclerosis means a definite diagnosis of at least one of the following: • two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; • well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or • a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart. The diagnosis of multiple sclerosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.
Occupational HIV infection	Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the covered person's normal occupation, which exposed the person to HIV contaminated body fluids. For any amount of coverage, the accidental injury leading to the infection must have occurred after the later of: • the date a person enrols for such amount of coverage; or • the effective date of such amount of coverage. If a person's Critical Illness coverage ends but the person is covered again under this benefit, 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 or the United States; and • the accidental injury must have been reported, investigated and documented in

	accordance with current Canadian or United States workplace guidelines. The diagnosis of occupational HIV infection must be made by a specialist physician. The covered person must survive for 30 days following the date of the second serum HIV test described above. Exclusions: No benefit will be payable under this condition if: • the covered person has elected not to take any available licensed vaccine offering protection against HIV; • a licensed cure for HIV infection has become available prior to the accidental injury; or • HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.
Paralysis	Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist physician. The covered person must survive for 90 days following the precipitating event.
Parkinson's disease	Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The covered person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease. Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist or a specialist physician. The covered person must satisfy the above conditions and survive for 30 days following the date all these conditions are met. Moratorium Period Exclusion: If, within 1 year following the later of: • the date a person enrols for any amount of coverage; or • the effective date of such amount of coverage, the covered person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage), regardless of when the diagnosis is made; or • a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage), no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders for those additional amounts. All other coverage remains in force. No benefit will be payable under Parkinson's disease and specified atypical parkinsonian disorders for any other type of parkinsonism.

	The information described above must be reported to us within 6 months of the date of diagnosis. If this information is not provided, we have the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment. If a person's Critical Illness coverage ends but the person is covered again under this benefit, we will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.
Severe burns	Severe burns means a definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist physician. The covered person must survive for 30 days following the date the severe burn occurred.
Stroke (cerebrovascular accident)	Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with: • acute onset of new neurological symptoms; and • new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis. Exclusions: No benefit will be payable under this condition for: • transient ischaemic attacks; • intracerebral vascular events due to trauma; or • lacunar infarcts which do not meet the definition of stroke as described above.
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 your children or your spouse's children 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 your children or your spouse's children 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, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol.

Child moratorium period exclusion

Any child of yours 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 amount of coverage that:

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

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

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

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

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 another critical illness policy without providing proof of good health.

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

At the time that you and/or your spouse apply to transfer group Critical Illness coverage to another critical illness policy, you or your spouse may also apply to transfer the group Critical Illness coverage for any covered children. We will not require the child's proof of good health. However, if either you or your spouse maintain coverage under this plan, the Critical Illness coverage for the child cannot be transferred.

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

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

Teladoc Medical Experts

The services offered by Teladoc Medical Experts are not insured or administered by Sun Life.

If you or your spouse are covered for Critical Illness, you, your spouse, your children, your parents and your parents-in-law have access to Teladoc Medical Experts. If only your children are covered for Critical Illness, no access to Teladoc Medical Experts is provided.

Teladoc Medical Experts 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 learn more about Teladoc Medical Experts services, or to use these services, please call Teladoc Medical Experts at 1-877-419-2378.

Liability and responsibility of Sun Life

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

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

Life Coverage

Insurer

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

General description of the coverage

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

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Who we will pay	If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. If a dependent dies, we will pay you the benefit for that dependent. For your spouse's optional coverage, we will pay the full amount of the benefit to the last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to you. **Fact** If you designated a beneficiary under a previous group plan of the employer, we will apply and carry it forward to your coverage under this plan until you change it. There are different rules for designating a minor beneficiary, please refer to your contract for specific information.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions.
Coverage during total disability	Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 65, whichever is earlier, as long as you are totally disabled. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations. There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact your employer for details.

Converting Life coverage

If your Life coverage or your spouse’s Life coverage ends or reduces for any reason other than your request, you or 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 because your Life coverage has ended, 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 that the Life coverage reduces or ends.

Important
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.

Accidental Death & Dismemberment (AD&D) Insurance

Insurer

This benefit is insured by SSQ, Life Insurance Company.

Accidental Death & Dismemberment (AD&D) Insurance provider is SSQ, Life Insurance Company. For more information regarding this benefit please see the AD&D booklet that can be found on the Hub or call ICBC HR Service Centre at 604-982-6675 or 1-844-982-6675.

Respecting your privacy

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

You have a choice

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

Life’s brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
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