Sun Life Financial

your group benefits

Nisichawayasihk Cree Nation

All employees with native status

Contract Number 82085
Effective April 1, 2009

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Benefit Summary

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

General Information

Waiting Period	90 days of continuous employment
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of your booklet.

Extended Health Care

Benefit year	January 1 to December 31
Deductible	None
Reimbursement level	
Prescription drugs	100%
In-province hospital	100% of the difference between the cost of a ward and a semi-private hospital room
Convalescent hospital	100% of the difference between the cost of a ward and a semi-private room for a maximum of 180 days for treatment of an illness due to the same or related causes
Out-of-province emergency services	100% Emergency Travel Assistance included Maximum of 60 days per trip Lifetime maximum of $1,000,000 per person for out-of-Canada services
Out-of-province referred services	100%

Medical services and equipment	100%
Paramedical services	100% up to a maximum of $500 per person per benefit year per specialty
Vision care	100% up to a maximum of $200 in any 12 month period for a person under age 18 or in any 24 month period for any other person
Termination	When you retire or reach age 65, whichever is earlier

Dental Care

Benefit year	May 1 to April 30
Deductible	None
Fee guide	The current fee guide for general practitioners in your province of residence
Reimbursement level	
Preventive procedures	100%
Basic procedures	100%
Major procedures	50%
Orthodontic procedures	50%, only for children under age 19
Maximum benefit	
Benefit year maximum	$1,500 per person TMJ and Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.
Lifetime maximum	TMJ procedures – $1,000 per person Orthodontic procedures – $1,500 per person
Late applicant maximum	If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum benefit is $300 per person during the first 3 years for Orthodontic procedures, and $100 per person during the first year for all other expenses
Termination	When you retire or reach age 65, whichever is earlier

Short-Term Disability

Maximum amount	75% of your weekly basic earnings up to a maximum of $1,000 The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Short-Term Disability* section of your booklet
Elimination period	Accident – none Illness – 7 days of uninterrupted total disability
Maximum benefit period	17 weeks
Termination	When you retire or reach age 65, whichever is earlier

Long-Term Disability

Maximum amount	75% of your monthly basic earnings up to a maximum of $5,000 The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Long-Term Disability* section of your booklet
Elimination period	17 weeks
Maximum benefit period	The period ending on the last day of the month in which you reach age 65 Benefits may also end on an earlier date as specified in the *Long-Term Disability* section of your booklet
Termination	The day you reach age 65 less the elimination period or the day you retire, whichever is earlier

Life

Employee Life

Amount	$50,000
Termination	When you retire or reach age 65, whichever is earlier

Dependent Life

Amount	Spouse – $10,000 Child – $5,000
Termination	When you retire or reach age 65, whichever is earlier

Accidental Death and Dismemberment

Employee Accidental Death and Dismemberment

Amount	Equal to Employee Life coverage
Termination	When you retire or reach age 65, whichever is earlier

General Information

About this booklet

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

Your group benefits may be modified after the effective date of this booklet. You will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

If you have any questions about the information in this employee benefits booklet, or you need additional information about your group benefits, please contact your employer.

Eligibility

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

- you are a permanent employee working in Canada.
- you are actively working for your employer at least 30 hours a week.
- you have completed the waiting period. Any period during which you do not meet the above eligibility requirements cannot be counted as part of the waiting period.

The waiting period for your group plan is 90 days of continuous employment.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

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

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

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

Enrolment

You have to enrol to receive coverage. To enrol, you must send the appropriate enrolment information to Sun Life through your employer. For a dependent to receive coverage, you must request dependent coverage.

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

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

When coverage begins

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

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

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

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

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

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

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

Changes affecting your coverage

From time to time, there may be circumstances that could lead to a change in your coverage. For example, your employment status may change, or your employer may change the group contract.

Any resulting change in the coverage will take effect on the date of the change in circumstances.

For a commissioned salesperson, any change in coverage resulting from a change in basic earnings will take effect on the following February 1. If the earnings change takes effect on February 1, then the change in coverage will take effect on that same day.

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

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

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.

When coverage ends

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

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

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

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

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

Surviving dependent coverage

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

- 24 months after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your coverage would have terminated if you were still alive.

- the date the benefit provision under which the dependent is covered terminates.

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

Replacement coverage

The group contract will be interpreted and administered according to the guidelines of the Canadian Life and Health Insurance Association or any applicable legislation concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of your total disability, Sun Life will resume payment at the same amount subject to all terms and conditions of the group contract.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim. There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. All claims must be made in writing on forms approved by Sun Life.

No legal action may be brought by you more than one year after the date we must receive your claim forms or more than one year after we stop paying disability benefits.

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical examinations

We can require medical examinations of any person for whom a claim is made. We will pay for the cost of these examinations. If the person fails or refuses to have an examination, we will not pay any benefit.

Recovering overpayments

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

Assignments

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

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

Definitions

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

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

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

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

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

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

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

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

Extended Health Care

General description of the coverage

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

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

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

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Prescription drugs

We will cover the cost of drugs and contraceptives which by law are only available with a prescription as long as they are prescribed by a doctor or dentist and are obtained from a pharmacist.

This coverage also includes:

- intrauterine devices (IUDs), diabetic and colostomy supplies.
- drugs for the treatment of infertility up to a lifetime maximum of $2,400 for each person.
- products to help a person quit smoking that require a prescription, up to a lifetime maximum of $500 for each person.

For the above items, we will only pay for quantities that can reasonably be used in a 3 month period.

We will cover 100% of the cost of the above medicines and supplies.

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

- the cost of giving injections, serums and vaccines.
- medicines obtained from a doctor or dentist.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- products to help a person quit smoking that do not require a prescription.
- drugs for the treatment of erectile dysfunction.
- any drugs covered under the Non-Insured Health Benefits Program.

Other health professionals allowed to prescribe drugs

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Hospital expenses in your province

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

We will cover out-patient services in a hospital and the difference between the cost of a ward and a semi-private hospital room.

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

Convalescent hospital

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

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

A *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Expenses out of your province

We will cover emergency services while you are outside the province where you live. We will also cover referred services.

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

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

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

Emergency services

We will pay 100% of the cost of covered emergency services.

We will only cover emergency services obtained within 60 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

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

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

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

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

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

Emergency services excluded from coverage

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 100% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

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

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $1,000,000 per person or, if lower, any other applicable lifetime maximum.

Medical services and equipment

We will cover 100% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $25,000 per person per benefit year.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.

- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, up to a maximum of $50 per person over 2 benefit years.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- wigs following chemotherapy, up to a maximum of $300 per person in a benefit year. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $350 per person in a benefit year.

- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $500 per person in a benefit year.
- hearing aids, up to a maximum of $500 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- blood glucose monitors, up to a lifetime maximum of $700 per person.

Paramedical services

We will cover 100% of the costs, up to a maximum of $500 per person per specialty in a benefit year for the paramedical specialists listed below:

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

Vision care

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

We will cover 100% of these costs up to a maximum of $200 in any 12 month period for a person under age 18 or in any 24 month period for any other person.

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

When coverage ends

Extended Health Care coverage will end when the employee retires or reaches age 65, whichever is earlier.

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

Payments after coverage ends

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

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

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

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

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

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.

When and how to make a claim

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

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

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

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

Emergency Travel Assistance

General description of the coverage

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

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

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 60 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

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

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

Getting help

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

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

Europ Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

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

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

Limits on Emergency Travel Assistance coverage

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

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

- rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or act of God.
- refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Europ Assistance

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

Dental Care

General description of the coverage

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

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

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

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

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

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

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

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

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

The benefit year is from May 1 to April 30.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than $1,500 per person for each benefit year for all services.

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

Lifetime maximum

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

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $1,500.

Restriction on payments

If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum amount we will pay for all Orthodontic procedures is $300 per person for the first 3 years of coverage.

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

Predetermination

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

Preventive dental procedures

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

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

Oral examinations

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

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

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

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

X-rays

You are covered for all the following x-rays:

- 4 bitewing x-rays in any 6 month period. A bitewing x-ray is a routine check-up x-ray used to detect decay in molar teeth.
- 1 complete series of x-rays or 1 panorex every 36 months. A complete series of x-rays is 10-14 individual x-rays, including bitewings, showing all the teeth in the mouth. A panorex is a large panoramic view of the entire mouth.
- 4 x-rays of single teeth, called periapical x-rays, in any 60 day period.
- 2 occlusal x-rays in any 12 month period.
- 2 extra oral x-rays in any 12 month period.

Test and lab exams

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

Polishing

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

Scaling and root planing

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

You are covered for up to 15 units of 15 minutes of tartar removal in any 12 month period.

Topical fluoride treatment

You are covered for 1 treatment every 6 months.

Oral hygiene instruction

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

Disking

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

Space maintainers and maintenance

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

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

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

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

Caries, trauma and pain control

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

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

Basic dental procedures

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

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

Fillings

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

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

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

Retentive pins

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

Pre-fabricated metal or plastic restorations

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

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

Pit and fissure sealants

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

Endodontics

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

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

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

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

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

Root amputation. This procedure includes recontouring tooth and furca.

Hemisection. You are covered for this procedure.

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

Periodontics Periodontics is the treatment of bone and gum disease.

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

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

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

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

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

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

- provisional splinting. This procedure includes tooth preparation, acid etch, wire replacement, acrylic or composite filling, occlusal adjustment, and 3 month follow-up care. You are covered for 1 unit of 15 minutes per joint. Replacements must be separated by at least 24 months.
- occlusal adjustment. You are covered for treatments to adjust your bite for 1 unit of 15 minutes for each office visit and 2 units of 15 minutes in any 12 month period. This treatment is only available when you have gum surgery or temporomandibular joint (TMJ) treatment.
- periodontal appliance. Includes impression, insertion and adjustments within 6 months of insertion. Replacements must be separated by at least 12 months. A periodontal appliance is used to treat gum disease.
- periodontal appliance adjustment or reline. You are covered for 1 unit of 15 minutes in any 12 month period.

Oral surgery

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

- extraction of erupted tooth – uncomplicated. Limited if additional teeth extracted in the same quadrant.

- extraction of erupted tooth – complicated. Limited if additional teeth extracted in the same quadrant. Surgery requires surgical flap or sectioning of the tooth.
- extraction of impacted tooth – soft tissue impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue and extraction of impacted tooth.
- extraction of impacted tooth – partial bone impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and either removal of bone and tooth or sectioning and removal of tooth.
- extraction of impacted tooth – complete bone impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and removal of bone and sectioning and removal of tooth.
- extraction of residual root. Limited if additional teeth extracted in the same quadrant.
- surgical exposure of impacted tooth. Limited if additional teeth exposed in the same quadrant.
- alveoloplasty. This procedure includes remodelling, excision, removal and reduction of bone.
- other procedures: stomatoplasty, remodelling mouth floor, vestibuloplasty, ridge reconstruction, and mucus fold extension; surgical excision of tumours; surgical excision of cysts; surgical incision and drainage; surgical removal of foreign body; repairs of lacerations; frenectomy; salivary gland treatment; and antral surgery.

Related surgical services

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

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

Repairing, relining or rebasing dentures

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

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

Major dental procedures

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

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

Inlays, onlays and gold foil restorations

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

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

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

Crowns

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

Veneers

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

Dentures

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

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

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

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

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

Tissue conditioning You are covered for this procedure.

Fixed bridges The alternate benefit provision may be applied, we will only pay for the least expensive alternate procedure when considering the cost of a bridge.

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

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

You are also covered for the following procedures:

- repairing fixed bridges.
- recementing fixed bridges.

TMJ treatment

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

Miscellaneous

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

Orthodontic procedures

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

Only children under age 19 are covered for these procedures.

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

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

The following orthodontic procedures are covered:

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

When coverage ends

Dental Care coverage will end when the employee retires or reaches age 65, whichever is earlier.

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

Payments after coverage ends

If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.

- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- charges related to the temporomandibular joint (TMJ) treatment, except otherwise indicated in the list of covered expenses.
- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

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

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

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

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

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

Short-Term Disability

General description of the coverage

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

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

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

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

When disability payments begin

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

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

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

If benefits are payable for part of any week, we will pay 1/7 of the weekly benefit for each day for which you are entitled to a benefit payment.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for at least 7 uninterrupted days in the case of illness and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer. In the case of an accident, you must be totally disabled on the date you are recalled or scheduled to return to full-time work.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous total disability if it occurs within 2 weeks of the end of your previous disability. You must be covered when the total disability reoccurs.

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

What we will pay

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

Step 1: We take 75% of your weekly basic earnings up to a maximum of $1,000.

If your Short-Term Disability benefit is less than the benefit that would be payable under the Employment Insurance Act, your basic earnings will be increased by the amount of bonus, commission, overtime or incentive pay earned on a regular basis, required to calculate the amount of benefit payable under the Employment Insurance Act.

Step 2: We subtract any benefits or payments provided:

- under a motor vehicle insurance plan which provides disability benefits or payments as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.
- under a group plan, including a multiple-employer group plan but excluding any benefits or payments provided under a Critical Illness plan or an association plan.

- as part of a salary continuance received from your employer during your disability.
- under the Québec Parental Insurance Plan.

After the first 17 weeks of total disability, when the maximum benefit period is more than 17 weeks, we also subtract any benefits or payments provided:

- for the same or a subsequent disability under any government-sponsored plan, such as the Canada Pension Plan and the Québec Pension Plan excluding all benefits or payments on behalf of a dependent, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under any coverage resulting from your membership in an association of any kind but excluding any benefits or payments provided under a Critical Illness plan.

The result from Step 2 is the amount you would normally receive as a Short-Term Disability payment. However, if the amount calculated under Step 2, plus the above sources of benefits and payments, exceeds 85% of your pre-disability basic earnings (after income tax, if the benefit is non-taxable), your Short-Term Disability payment is reduced by the excess.

If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Short-Term Disability payments.

If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.

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

We have the right to adjust your Short-Term Disability benefit payments when appropriate under the above provision.

Maternity / parental leave of absence

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

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

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

Short-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for 7 uninterrupted days, provided your coverage has been continued.

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

Rehabilitation program

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

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

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

During your rehabilitation program, you may receive Short-Term Disability payments plus income, benefits and payments from other sources. However, if during any week the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began (less provincial and federal income taxes if your benefit is non-taxable), your Short-Term Disability payment will be reduced by the excess.

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

If you recover damages from another person

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

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

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

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

When payments end

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

- the date you are no longer totally disabled.
- the end of a maximum benefit period of 17 weeks of payment.
- the date you retire on pension.
- the date you die.

When coverage ends

Your Short-Term Disability coverage will end on the day you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

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

- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence*. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

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

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

We will not pay for total disability resulting from:

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

When and how to make a claim

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

In order for you to receive benefits, we must receive these forms no later than 30 days after your total disability begins.

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

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

Long-Term Disability

General description of the coverage

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

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

For your Long-Term Disability coverage,

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

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

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

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

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

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 17 weeks or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

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

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 17 weeks and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

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

Step 1: We take 75% of your monthly basic earnings up to a maximum of $5,000.

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

- for the same or a subsequent disability under any government-sponsored plan, such as the Canada Pension Plan and the Québec Pension Plan excluding all benefits or payments on behalf of a dependent, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a motor vehicle insurance plan which provides disability benefits or payments to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind but excluding any benefits or payments provided under a Critical Illness plan.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under the Québec Parental Insurance Plan.

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

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

Additional sources of benefits and payments are those provided:

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

If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Long-Term Disability payments.

If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.

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

We have the right to adjust your Long-Term Disability benefit payments when appropriate under the above provision.

Maternity / parental leave of absence

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

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

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

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 17 weeks, provided your coverage has been continued.

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

Partial disability program

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

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

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

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

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

Rehabilitation program

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

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

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

During your rehabilitation program, you may receive your Long-Term Disability payments plus income, benefits and payments from other sources. However, if during any month the total of any income, benefits and payments provided is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long-Term Disability payments will be reduced by the excess.

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

Interrupted periods of disability during elimination period

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

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

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

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

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability. You must be covered when total disability reoccurs.

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

If you recover damages from another person

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

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

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

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

Your responsibilities

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

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

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

When payments end

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

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

Survivor Benefit

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

When coverage ends

Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 17 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

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

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

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

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

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

We will not pay benefits for total disability resulting from:

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

Waiver of premium

Long-Term Disability premiums will be waived while you are receiving Long-Term Disability benefits.

When and how to make a claim

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

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

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

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

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

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

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

Life Coverage

General description of the coverage

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

Life coverage for you

Amount

Your Life benefit is $50,000.

Coverage ends

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

Life coverage for your dependents

Amount

Your spouse's benefit is $10,000. Your children's benefit is $5,000 per child.

Coverage ends

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

Who we will pay

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

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

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

Coverage during total disability

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

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

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

Total disability must continue for:

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

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

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

Retirement Date

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

Converting Life coverage

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

If your spouse's Life coverage ends for any reason other than your request, your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health. This is not available for dependent children.

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

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

When and how to make a claim

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

Accidental Death and Dismemberment

General description of the coverage

Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you die or suffer any of the losses listed in the table under *What we will pay*. Any death benefit paid under this coverage is in addition to the Life coverage.

Accidental coverage for you

Amount

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

Coverage ends

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

What we will pay

We will pay for this benefit if you:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you are still alive.
- are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages we use to determine the payment.

TABLE OF LOSSES

Loss of life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%

Loss of one arm or one leg	75%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33 1/3%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four toes on the same foot	25%
Loss of use of both arms or both legs	100%
Loss of use of both hands or both feet	100%
Loss of use of one arm or one leg	75%
Loss of use of one hand or one foot	75%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. We will not pay more than 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay a maximum of 200%.

Loss of an arm means that it was severed at or above the elbow. Loss of a hand means that it was severed at or above the wrist. Loss of a leg means that it was severed at or above the knee. Loss of a foot means that it was severed at or above the ankle. Loss of a thumb, finger or toe means that it was severed at or above the first joint from the hand or foot. Loss of sight, speech or hearing must be total and permanent.

Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

Limit on benefit amounts

If more than one person covered by the group contract is eligible for benefits resulting from the same accident, Sun Life will pay up to a maximum of $3,000,000 for all claims related to the accident.

If the total amount of benefits payable for the accident is more than $3,000,000, then we will pay for each person a percentage of the $3,000,000 that is equal to the percentage the person would have received of the total payable.

Repatriation benefit

If you die as a direct result of an accident 100 kilometres or more from home, we will pay up to $10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.

Rehabilitation program

If you suffer a loss, other than a loss of life, we will pay up to $10,000 of your rehabilitation expenses. We will only pay for the usual and reasonable expenses connected with a rehabilitation program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the rehabilitation program and the expenses must be incurred within 3 years of the accident and while you are covered for this benefit. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the rehabilitation program will be based on the likelihood that it will be successful. The rehabilitation will be made up of training required, because of the loss, to prepare you for a new occupation.

Spouse occupational training benefit

If you die as a direct result of an accident, we will pay up to $5,000 to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the expenses and all expenses must be incurred within 3 years of the date of the accident. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the training program will be based on the likelihood that it will be successful.

Child education benefit

If you die as a direct result of an accident, we will pay for a dependent child's tuition fees in a post-secondary school. We will pay the child 5% of the amount of coverage up to $5,000, each year up to a maximum of 4 years. The child must enrol as a full-time student within one year of your death.

We will only pay for the usual and reasonable tuition expenses. This does not include ordinary living expenses such as room, board, travelling or clothing. This also does not include education expenses incurred prior to your death.

Family transportation benefit

If you suffer a loss as a direct result of an accident and are hospitalized at least 150 kilometres from home, we will pay up to $5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister.

We will only pay for the usual and reasonable travel expenses. We will pay for car travel at a rate of $0.20 per kilometre. Transportation must be by the most direct route to and from the hospital. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Coverage during total disability

If you become totally disabled while covered and premiums are no longer payable for Life coverage, your Accidental Death and Dismemberment coverage will continue without the payment of premiums, but not beyond age 65, for as long as premiums are not payable for your Life coverage.

Any amount of coverage continued is subject to the terms of this group plan when total disability began.

What is not covered

We will not pay for losses that are the result of:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.
- attempted suicide or suicide while sane or insane.
- flying in, descending from or being exposed to any hazard related to an aircraft while
  - receiving flying lessons.
  - performing any duties in connection with the aircraft.

- being flown for a parachute jump.
- a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence.

Converting coverage

If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy. The amount of this Accidental Death benefit cannot be more than the amount of Life coverage you are converting.

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

When and how to make a claim

For any loss other than death, the claim must be received by Sun Life within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

Respecting Your Privacy

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

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or send a written request by e-mail to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.

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