

your **group**
benefits

The Corporation of Haldimand County

Elected Officials

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The Accidental Death and Dismemberment benefit is insured by
Industrial Alliance Pacific Insurance and Financial Services Inc.

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General Information

The information contained in this section applies only to benefits insured by Sun Life Assurance Company of Canada.

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, full-time employee.

There is no waiting period for your group plan.

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.

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

Who qualifies as your dependent

dependents to be eligible.

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 request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request dependent coverage.

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

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

Proof of good health will not be required for yourself for the first \$30,000 of coverage if you request Optional Life coverage within 31 days of becoming eligible for coverage.

When coverage begins

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

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

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

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

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

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

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

- our website at www.mysunlife.ca.

- our Customer Care centre by calling toll-free at 1-800-361-6212.

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

- the date your term in office ends.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

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

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

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

- 24 months after the date of your death or the date you spouse turns age 65, whichever is earlier.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your spouse remarries.
- the date the benefit provision under which the dependent is covered terminates.

If you die while disabled and covered by this plan, coverage for your

dependents will continue, on a premium paying basis, until the day you would have reached 65.

Replacement coverage

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

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

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim.

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

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

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

Legal actions

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

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

Sun Life:

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

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

- the plan where the person is covered as an employee. If the

person is an employee under two plans, the following order applies:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Extended Health Care (Medicare Supplement)

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	<p>In this section, <i>you</i> means the employee and all dependents covered for Extended Health Care benefits.</p> <p>Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. <i>Medically necessary</i> 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.</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>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.</p> <p>The benefit year is from January 1 to December 31.</p>
Deductible	<p>The deductible is the portion of claims that you are responsible for paying.</p> <p>The deductible is \$10 each benefit year for each person up to a maximum of \$20 per family.</p> <p>After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.</p> <p>If 2 or more members of your family suffer injuries in the same accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.</p>

Prescription drugs

After you pay the deductible, we will cover 100% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$500 for each person.
- drugs for the treatment of infertility, up to a lifetime maximum of \$2,400 for each person.
- treatments for weight loss that require a prescription up to a maximum of \$1,800 in a benefit year for each person.
- oral drugs for the treatment of sexual dysfunction up to a maximum of \$1,200 in a benefit year for each person.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

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

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

-
- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
 - the cost of giving injections, serums and vaccines.
 - treatments for weight loss that do not require a prescription, including drugs, proteins and food or dietary supplements.
 - hair growth stimulants.
 - non-oral drugs for the treatment of sexual dysfunction.
 - drugs that are used for cosmetic purposes.
 - natural health products, whether or not they have a Natural Product Number (NPN).
 - drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

***Drug substitution
limit***

Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

***Prior authorization
program***

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

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

You will be covered for these drugs if the information you and your doctor provide meets our medical criteria. If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

***Other health
professionals allowed
to prescribe drugs***

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

**Hospital expenses in
your province**

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and a semi-private hospital room.

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

The maximum amount payable is \$3 per day up to a maximum of 120 days for treatment of an illness due to the same or related causes.

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

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

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 benefit year maximum of \$1,000,000 per person or, if lower, any other applicable lifetime maximum.

Referred services out of your province Expenses incurred for referred services outside the province where you live are subject to a benefit year maximum of \$50,000 per person or, if lower, any other applicable lifetime maximum.

Medical services and equipment We will cover 100% of the reasonable and customary costs after you pay the deductible 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 a licensed practical nurse, or a registered private nurse 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 \$10,000 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.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum \$150 for each person.
- wigs following chemotherapy, limited to one wig in a lifetime for each person. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost

of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair. Mechanical and hydraulic lifts are not covered.

- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery. Repairs and replacement once every 2 benefit years.
- surgical brassieres required as a result of surgery.
- artificial limbs and eyes. Myoelectric appliances are eligible at the cost of a regular prosthesis.
- stump socks.
- elastic support stockings, including pressure gradient hose.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, limited to one pair per benefit year 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, limited to one pair per person per benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$500 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- constant positive airway pressure (CPAP). Supplies are limited to \$400 once every 6 months.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of \$700 per person.
- insulin pumps.

Paramedical services

We will cover 100% of the costs after you pay the deductible, up to a maximum of \$300 per person per specialty in a benefit year for the paramedical specialists listed below:

- licensed psychologists or social workers.
- licensed speech therapists.

We will cover 100% of the costs after you pay the deductible, up to a maximum of \$350 per person per specialty in a benefit year for the paramedical specialists listed below:

- licensed naturopaths.
- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), 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.

We will not pay for the cost of services rendered by a podiatrist in Ontario unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

We will cover 100% of the costs, after you pay the deductible, up to a combined maximum of \$1,000 per person in a benefit year for the paramedical specialists listed below:

- licensed chiropractors, including a maximum of one x-ray examination each benefit year.
- a licensed physiotherapist.
- a licensed massage therapist, when ordered by a doctor. Every 12 months you will be required to submit a new recommendation from your doctor.

Contact lenses and eyeglasses

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

We will cover 100% of these costs, up to a maximum of \$350 in any 24 month period for each person.

We will also cover 100% of the costs for services of an ophthalmologist or licensed optometrist, limited to one examination per person in any 24 month period, included in the vision care maximum.

The deductible does not apply to eyeglasses, contact lenses.

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's term in office ends.

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

Payments after coverage ends

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

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

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

If the Extended Health Care benefit terminates, coverage for dental

services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

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

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

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

Integration with government programs

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

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

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer.

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

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

Emergency Travel Assistance

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	<p>In this section, <i>you</i> means the employee and all dependents covered for Emergency Travel Assistance benefits.</p> <p>If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (<i>Europ Assistance</i>) can help.</p> <p><i>Emergency</i> means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.</p> <p>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.</p> <p>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.</p> <p>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.</p>
Getting help	<p>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</p>

emergency.

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

Europ Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

mentally or physically handicapped.

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

- Limits on advances** Advances will not be made for requests of less than \$200. Requests in excess of \$200 will be made in full up to a maximum of \$10,000.
- The maximum amount advanced will not exceed \$10,000 per person per trip unless this limit will compromise your medical care.
- Reimbursement of expenses** If, after obtaining confirmation from Europ Assistance that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.
- To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.
- Your responsibility for advances** You will have to reimburse Sun Life for any of the following amounts advanced by Europ Assistance:
- any amounts which are or will be reimbursed to you by your provincial medicare plan.
 - that portion of any amount which exceeds the maximum amount of your coverage under this plan.
 - amounts paid for services or supplies not covered by this plan.
 - amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.
- Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.
- Limits on Emergency Travel Assistance coverage** There are countries where Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.
- Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:
- a rebellion, riot, military up-rising, war, labour disturbance,

strike, nuclear accident or an act of God.

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

**Liability of Sun Life
or Europ Assistance**

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

Dental Care

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

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 which was current one year prior to the date the eligible expenses were incurred, regardless of where the treatment is received.

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

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

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

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than \$2,000 per person for each benefit year for Basic dental procedures and Major dental procedures combined.

Predetermination

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

Preventive dental procedures

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

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

Oral examinations

1 complete examination every 36 months.

1 recall examination every 6 months for a person under age 18 and once every 9 months for any other person.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 36 months.

1 set of bitewing x-rays every 6 months for a person under age 18 and once every 9 months for any other person.

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

Other services

Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 6 months for a person under age 18 and once every 9 months for any other person.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 6 months for a person under age 18 and once every 9 months for any other person.

Anaesthesia in conjunction with a Preventive procedure covered under this plan.

Basic dental procedures

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

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

Fillings Amalgam, composite, acrylic or equivalent.

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

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

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

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

Rebase, repair or reline Rebase, repair or reline of an existing partial or complete denture once every 6 months.

<i>Oral surgery</i>	<p>Surgery, other than the removal of impacted teeth (<i>Preventive dental procedures</i>).</p> <p>Anaesthesia in conjunction with a Basic procedure covered under this plan.</p>
Major dental procedures	<p>Your dental benefits include the following procedures used to treat major dental problems.</p> <p>We will pay 50% of the eligible expenses for these procedures.</p>
<i>Major restorations</i>	<p>Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (<i>Basic dental procedures</i>).</p>
<i>Repair</i>	<p>Repair of bridges.</p>
<i>Prosthodontics</i>	<p>Construction and insertion of bridges or standard dentures. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:</p> <ul style="list-style-type: none">■ it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.■ it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required. <p>Anaesthesia in conjunction with a Major procedure covered under this plan.</p>
When coverage ends	<p>Dental Care coverage will end when the employee's term in office ends.</p> <p>Coverage may also end on an earlier date, as specified in <i>General Information</i>.</p>

Payments after coverage ends

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

What is not covered

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

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

We will not pay for:

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

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

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

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

Life Coverage

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Optional Life coverage provides a benefit if your spouse dies while covered.
Basic Life coverage for you	
<i>Amount</i>	Your Life benefit is 2 times your annual basic earnings, rounded to the next higher \$1,000. The maximum amount of coverage is \$150,000.
<i>Coverage ends</i>	Your coverage will end when your term in office ends.
Optional Life coverage for you	
<i>Amount</i>	You can choose coverage in units of \$10,000. The maximum amount of coverage is \$250,000.
<i>Proof of Good Health</i>	Proof of good health will be required for amounts over \$30,000 if you request coverage within 31 days of becoming eligible for coverage.
<i>Coverage ends</i>	Your coverage will end when your term in office ends or you reach age 65, whichever is earlier.
Optional Life coverage for your spouse	
<i>Amount</i>	You can choose Optional Life coverage for your spouse in units of \$10,000 up to a maximum of \$250,000.
<i>Coverage ends</i>	Optional coverage for your spouse will end when your term in office ends, you reach age 65, or when your spouse reaches age 65, whichever is earlier.

Who we will pay

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

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

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

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

Suicide

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, while sane or insane. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

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

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

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

Total disability must continue for at least an uninterrupted period of 6 months.

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

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

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

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.

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

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

**When and how to
make a claim**

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

Basic Accidental Death And Dismemberment Insurance

Insurer **This benefit is issued by Industrial Alliance Pacific Insurance and Financial Services Inc.**

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are covered for a principal sum amount of 2 times Annual Earnings, adjusted to the next higher \$1,000.00 if not already a multiple thereof, subject to a maximum benefit of \$150,000.00, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

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

	% of Principal Sum
Life	100%
Both Hands or Both Feet or Entire Sight of Both Eyes	100%
One Hand and One Foot or One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye or Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot or Entire Sight of One Eye or Speech or Hearing in both Ears	66 2/3%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	33 1/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs) or Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREVEMENT BENEFIT (\$1,000)

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

REPATRIATION BENEFIT (\$15,000)

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

IDENTIFICATION BENEFIT (\$10,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters.

FUNERAL EXPENSE BENEFIT (\$5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

SPOUSAL RETRAINING BENEFIT (\$15,000)

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

EDUCATION BENEFIT (\$10,000)

If injury results in loss of life, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there is no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of \$2,500.00 to the designated beneficiary.

DAY CARE BENEFIT (\$5,000)

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

PARENTAL CARE BENEFIT (\$5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum to any eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in the insured's residence, or receiving support and care provided by the insured.

SEAT BELT BENEFIT

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

HOSPITAL INDEMNITY EXPENSE (\$2,500)

A daily benefit, subject to the above-mentioned monthly maximum, will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury

which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity of the policy and begins while insurance is in force.

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

FAMILY TRANSPORTATION BENEFIT (\$15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured.

REHABILITATION BENEFIT (\$15,000)

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

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT (\$15,000)

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

WAIVER OF PREMIUM

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

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability. This continuation is subject to continued payment of premiums and is granted for a maximum of 12 months (or to age 65 if on disability leave) or on the date the insured returns to work, whichever is earlier.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination.

Application for conversion must be made within 31 days. Premiums become payable annually in advance.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date the term in office of an insured ends; (d) the premium due date next following the date an insured is ineligible for coverage.

LIMITED AIR TRAVEL COVERAGE

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

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

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

WHEN DOES THIS INSURANCE NOT APPLY?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled "Limited Air Travel Coverage".

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This group Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy, not this summary.

Respecting your privacy

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

You have a choice

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

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

