Montfort

Your Group Insurance Plan

ONTARIO NURSES ASSOCIATION (ONA)
HIRED PRIOR TO JANUARY 1, 2006

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Keep this Booklet in a Safe Place

Your group benefits provide an important supplement to your income and valuable protection to you and your family.

This document contains important information about your employee benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

Although all information provided herein is meant to be exact and accurate, this document has no legal value. Only the terms and conditions of the group insurance policy and any applicable laws will be used to settle legal issues.

The insurers and administrators of these benefits are as follows:

Benefit	Insurer / Administrator	Policy Number
Group life insurance, optional life insurance and long-term disability (LTD) insurance	Sun Life Assurance Company of Canada (Sun Life)	**101935**
Optional Critical Illness Insurance		**105229**
Accidental death & dismemberment (AD&D) insurance	AIG Insurance Company of Canada	**BSC 9424749**
Extended health care and dental care coverage	Hôpital Montfort Administered by Coughlin & Associates Ltd.	**27011**
Out-of-province/Canada medical emergency insurance coverage	AIG Insurance Company of Canada	**CMG 9428930**

If you have questions about your group benefits that are not covered in this booklet, please contact Coughlin & Associates Ltd., your plan administrator, at 613-231-2266, or toll-free 1-888-613-1234, or fax 613-231-2345, or e-mail at info@coughlin.ca or contact Hôpital Montfort Human Resources office.

If there are any discrepancies between the group contract and the employee benefits booklet, your coverage will be determined by the terms and conditions of the group contract.

Important

This document contains important information about your employee benefits coverage and should be kept in a safe place. It supersedes and replaces all previous communications material and is the plan document in respect to the benefits described herein.

Hôpital Montfort, the plan sponsor, underwrites certain benefits on a self-insured basis as indicated in the table on the previous page. All risks in respect to these benefits are borne by Hôpital Montfort.

As sponsor of the plan, Hôpital Montfort or its trustees or designates may establish rules or regulations for the administration or governance of the benefits plan and any transactions associated with it. They also have the right to interpret the self-funded coverage of the plan and decide any and all matters related to it. This includes the right to clarify or remedy any possible uncertainties, omissions or inconsistencies based on applicable laws and the reasonable and customary charges and treatment for the self-funded benefits described in this booklet.

The interpretations or decisions of Hôpital Montfort, its trustees or designates with respect to the self-insured coverage, will be final and binding on all parties.

Protecting Your Personal Information

The administrator of your group benefits plan is Coughlin & Associates Ltd. (“Coughlin”). Coughlin recognizes and respects every individual’s right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the group benefits plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at www.coughlin.ca, or send a written request to our Privacy Officer by mail or by email at privacy@coughlin.ca.

Errors or Omissions

Every effort has been made to ensure that this booklet is accurate and complete. Should an error, omission or dispute occur, the terms of the policies issued to the plan sponsor will prevail. Clerical errors made by the plan administrator will not invalidate benefits otherwise in force or continue benefits otherwise terminated.

Any fraud or willfully false statement in making a claim may invalidate your claim. You are not entitled to the claimed benefit. Sometimes, an overpayment situation may occur through no fault of yours. This means you received a greater benefit payment than you were entitled to receive. If you receive a benefit to which you are not entitled, you must immediately repay that amount to the plan sponsor, to Coughlin & Associates Ltd., which administers your group benefit plan on behalf of the plan sponsor, or to the insurer. If you receive benefits to which you are not entitled and do not repay them, any one or more of the following may occur:

a) any benefit payments to which you are entitled may be withheld to recover the amount you owe; and

b) criminal or other legal action may be brought against you.

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Benefits Summary

The following is a summary of your benefits plan. For further details on each benefit, please refer to the appropriate section of this booklet.

Eligibility: Must work a minimum of 30 hours per week. The waiting period is the first day of the month following or coinciding with the completion of twelve months of continuous employment for long-term disability. The first day of the month following or coinciding with the completion of one month of continuous employment for extended health care benefit. The first day of the month following or coinciding with the completion of three months of continuous employment for all other benefits.

Summary of Benefits

1. Employee Basic Life Insurance

Benefit amount:	Two times your annual salary rounded to the next $1,000, if not already a multiple.
Maximum amount:	$300,000.
Termination:	When you reach age 70, or retire, whichever occurs first.

2. Employee Optional Life Insurance

Benefit amount:	You can choose coverage in units of $10,000, subject to approval of evidence of insurability.
Minimal amount:	$10,000.
Maximum amount:	$400,000.
Termination:	When you reach age 70, or retire, whichever occurs first.

3. Spouse Optional Life Insurance

Benefit amount:	You can choose coverage in units of $10,000, subject to approval of evidence of insurability.
Minimal amount:	$10,000.
Maximum amount:	$400,000.
Termination:	When you reach age 70, or retire, or when your spouse reaches age 70, or is no longer your spouse, whichever occurs first.

4. Child Optional Life Insurance

Benefit amount:	$10,000, subject to approval of evidence of insurability.
Termination:	When you reach age 70, or retire, or when the dependent child ceases to qualify under the definition of dependent, whichever occurs first.

5. Basic Accidental Death & Dismemberment (AD&D)

Benefit amount:	Two times your annual salary rounded to the next $1,000, if not already a multiple.
Maximum amount:	$300,000.
Termination:	When you reach age 80, or retire, whichever occurs first.

6. Long-Term Disability (LTD) Insurance

Benefit amount:	If you have at least 1 year of service, but less than 10 years of service: 60% of your monthly basic earnings, rounded to the next higher $1. If you have at least 10 years of service, but less than 20 years of service: 65% of your monthly basic earnings, rounded to the next higher $1. If you have at least 20 years of service, but less than 30 years of service: 70% of your monthly basic earnings, rounded to the next higher $1. If you have at least 30 years of service: 75% of your monthly basic earnings, rounded to the next higher $1.
Non-Evidence maximum:	$12,000, and any increase in that coverage of 25% or more or $500, whichever is greater.
Maximum amount:	$20,000.
Maximum benefit period:	Period ending on the day you reach age 65 if the elimination period is completed on or before the date you reach age 64. The date you have received 12 months of long-term disability payments if the elimination period is completed after you reach age 64 but before you reach age 65.
All-source maximum:	100% of gross monthly earnings.
Elimination period:	210 days.
Tax status:	Benefits are taxable.
Termination:	When you reach age 65, or retire, whichever occurs first.

7. Employee Optional Critical Illness Insurance

Benefit amount:	You can choose coverage in units of $10,000.
Minimum amount:	$20,000.
Maximum amount:	$200,000.
Non-evidence maximum:	Approval required on the initial optional amount of coverage, except for the first $50,000 if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee.
Termination:	When you reach age 65, or retire, whichever occurs first. In addition, your coverage will end on the date a critical illness benefit is paid for a covered condition which you sustain.

8. Spouse Optional Critical Illness Insurance

Benefit amount:	You can choose coverage in units of $10,000.
Minimum amount:	$20,000.
Maximum amount:	$200,000.
Non-evidence maximum:	Approval required on the initial optional amount of coverage, except for the first $50,000 if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee.
Termination:	When you reach age 65, or retire, or when your spouse reaches age 65, whichever occurs first. In addition, your spouse's coverage will end on the date a critical illness benefit is paid for a covered condition which your spouse sustains.

9. Child Optional Critical Illness Insurance

Benefit amount:	You can choose coverage in units of $5,000 per child.
Maximum amount:	$20,000.
Non-evidence maximum:	Approval required on the initial optional amount of coverage, except if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee. The child is eligible for this benefit only if the employee or spouse is covered for Critical Illness insurance.
Termination:	When you reach age 65, or retire, whichever occurs first. In addition, coverage for any child will end on the date a critical illness benefit is paid for a covered condition which your child sustains.

10. Extended Health Care Benefits

Deductible:	$22.50 per insured person, $35 per family each calendar year. Professional and paramedical services and medical supplies and services: combined deductible of $22.50 per insured person, $35 per family each calendar year.
Reimbursement level:	100% of all eligible expenses (unless otherwise specified). 80% for referral treatment.
Maximum benefit:	Unlimited.
Termination:	At retirement.

Note: Some individual benefits are subject to monthly, yearly or lifetime maximums.

Prescription drugs:

• Deductible:	Indicated under extended health care benefits above.
• Reimbursement level:	100%, except as noted elsewhere in this booklet.
• Eligible drugs:	Drugs, serums and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner or dentist dispensed by a pharmacist, dentist or a physician.
• Drug card:	Yes.
• Generic substitutions:	Mandatory unless the physician indicates “no substitution”.
• Maximums and exclusions:	
- Drugs:	Limited to 3 months supply.
- Preventive vaccines prescribed by a physician:	Excluded.
- Sclerosing injections for the treatment of varicosities:	$15 per visit per insured person.
- Viscosupplementation:	Included, up to reasonable and customary charges.
- Smoking cessation aids (products only):	Excluded.
- Sexual dysfunction drugs:	Excluded.
- Fertility treatment:	Lifetime maximum of six months of treatment per insured person.

Prior authorization may be required by the plan administrator for certain medications.

Hospital care:

• Reimbursement level:	100% of eligible expenses.
• Coverage:	Cost of a semi-private room or private room for each day of hospitalization.

• Chronic care:	Cost of a semi-private room, up to a maximum amount of $3 per day, and a maximum duration of 120 days per calendar year.

Vision care (eyeglasses, contact lenses and laser eye surgery):

• Reimbursement level:	100% of eligible expenses including contact lenses (special conditions).
• Maximum:	$450 per insured person every 24 consecutive months for adults and children. The maximum is combined with the payable maximum under the *Eye examinations, including eye refraction* benefit.
• Laser eye surgery:	One time consideration only. Combined maximum with eyeglasses and contact lenses.
• Glasses or contact lenses following cataract surgery:	One pair, up to a maximum of $300 per insured person per period of 24 consecutive months.
• Artificial crystalline lenses, also known as intraocular lenses (IOL) for cataracts:	Included, up to reasonable and customary charges.
• Eye examinations, including eye refraction:	One exam per insured person for any period of 24 consecutive months in the case of adults and children under age 18. The maximum is combined with the payable amount maximum for the *Vision care (eye glasses, contact lenses and eye correction surgery)* benefit.
• Visual training:	$250 lifetime maximum per insured person.

Professional and paramedical services:

• Reimbursement level:	100%.
• Maximum per practitioner:	
– Chiropractor:	$450 per insured person per calendar year.
– Dietician*:	$200 per insured person per calendar year.
– Massage therapist*:	$450 per insured person per calendar year.
– Psychologist, social worker or psychotherapist:	Unlimited.
– Speech therapist*:	$200 per insured person per calendar year.
– Physiotherapist:	$450 per insured person per calendar year.

* Physician's referral required. Medical recommendation to be renewed every 12 months.

Imaging techniques ordered by a chiropractor are covered and combined with the maximum payable amount specified above.

Medical supplies and services:

• Reimbursement level:	100%.
• Maximum per service and/or supply:	
– External breast prosthesis (following mastectomy):	Purchase of one prosthesis per insured person for any period of 2 calendar years.
– Surgical brassieres:	Purchase of 4 surgical brassieres per insured person per calendar year.
– Private duty nurse:	Unlimited.
– Artificial eye:	Purchase, including reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
– Stump socks:	Included up to reasonable and customary charges.
– Orthopaedic shoes:	Custom made: Purchase of one pair per insured person per calendar year.

	Prefabricated: Purchase of one per insured person per calendar year.
– Custom made orthotics or arch support:	Purchase up to a maximum of $300 per insured person per calendar year.
– Elastic support stockings:	Excluded.
– Conventional wheelchair:	Purchase or rental, up to reasonable and customary charges.
– Other therapeutic equipment:	Purchase or rental, up to a lifetime maximum of $10,000 per insured person.
– Hearing aids:	Purchase, including batteries, up to $700 per insured person for any period of 36 consecutive months. A written prescription by a licensed otolaryngologist is required.
– Diagnostic services:	$500 per insured person each calendar year.
– Wigs as result of chemotherapy:	Purchase up to a lifetime maximum of $500 per insured person.
– Glucometer or reflectant meter:	Excluded.
– TENS nerve stimulators:	Purchase or rental, up to a lifetime maximum of $700 per insured person.
– Intra-uterine devices:	Purchase, up to reasonable and customary charges.
– Out-of-province/Canada referral treatment:	Expenses incurred outside the province of residence, but in Canada: no maximum limitation. Expenses incurred outside Canada: up to a maximum of $50,000 per insured person each calendar year.

11. Out-of-Province/Canada Medical Emergency Insurance

Deductible:	Nil.
Reimbursement level:	100%.
Maximum amount:	Overall maximum of $5,000,000 per insured person per coverage period.
Coverage period:	180 days per trip.
Termination:	At retirement.

12. Dental Care Benefit

Deductible:	Nil.
Fee guide:	Based on the current Dental Association fee guide for general practitioners, denturists or specialists, where service is rendered.
Reimbursement amount:	
• Basic services:	100%.
– Maximum:	Unlimited.
• Major services:	50%.
– Maximum:	$2,000 per insured person per calendar year.
• Denture services:	50%.
– Maximum:	$1,000 per insured person per calendar year.
• Orthodontic services:	50% - eligible expenses for adults and children.
– Maximum:	Lifetime maximum of $2,000 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 3 calendar years.
• Recall oral examination:	Once every 6 consecutive months for dependant children. Once every 9 consecutive months for the member and the spouse.

• Specific oral examination:	Once every 6 consecutive months for the dependant children. Once every 9 consecutive months for the member and the spouse.
• Emergency oral examination:	Unlimited.
• Complete series of periapical films or panoramic radiographs:	Once every 24 consecutive months.
• Polishing:	Once every 6 consecutive months for dependant children. Once every 9 consecutive months for the member and the spouse.
• Bitewing radiographs:	Unlimited.
• Scaling and root planing:	12 units combined per calendar year.
• Fluoride treatment:	Once every 6 consecutive months for the dependant children. Once every 9 consecutive months for the member and the spouse.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Periodontics post-operative visits:	4 visits per calendar year.
• Curettage performed by a dentist:	Once per period of 60 months.
• Special periodontal appliances, including occlusal guards and bruxism appliances:	Limited to reasonable and customary charges.
• Adjustments to periodontal appliance to control bruxism:	One adjustment per calendar year.
• Pit and fissure sealants:	For children under age 16.
• Occlusal equilibration:	Limited to reasonable and customary charges.
• Space maintainers:	For missing primary teeth only for children under age 16.
• Oral hygiene instruction:	Excluded.
• Anaesthetic:	Only general anaesthesia and conscious sedation are covered if they are administered in conjunction with extractions (oral surgery).
• Denture adjustments including minor adjustments:	Once every 6 consecutive months.
• Denture rebase/reline:	Limited to reasonable and customary charges.
• Preformed stainless steel and polycarbonate crowns:	Included for children under age 16.
• Crowns, veneers, inlays & onlays:	Once every 5 calendar years. Porcelain crowns must be converted to metal for molar teeth.
• Bridges and dentures:	Once every 5 calendar years. Porcelain supports and pontics must be converted to metal for molar teeth.
• Implants	Included.
• Laboratory fees:	Limited to 50% of the fees specified for the dental treatment or service.
Termination:	At retirement.

Benefits Insured by Sun Life Assurance Company of Canada (Sun Life)

The wording in this section has been provided by Sun Life Assurance Company of Canada, who assumes sole responsibility in the case of any discrepancy between this wording and the policy issued by them.

General Information

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.

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

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

For administrative purposes, number 105229 will be used for the Critical Illness benefit under this contract.

We, our and us
Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada.

Waiting Period
You will be eligible for coverage on the 1st day of the month coincident with or next following the completion of:
- 12 months of continuous employment for long-term disability benefit.
- 3 months of continuous employment for all other benefits.

Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period.

Termination
Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Who is eligible to receive benefits?
To be eligible for group benefits, you must live in Canada and meet all the following conditions:
- you are a permanent employee working in Canada.
- you are actively working for your employer at least 30 hours per week.
- you have completed the waiting period indicated in the Benefit Summary.

Your dependents become eligible for coverage on the later of the following dates:
- on the date you become eligible for coverage, or
- on the date they become your dependent.

You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent
Your dependent must be :
- your spouse or your child, and
- living in Canada.

Your spouse qualifies as your dependent if they are your spouse in one of the following ways:
- by marriage
- under any other formal union recognized by law
- as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship

You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are under age 21 and do not have a spouse.

A child who is a full-time student until age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse.

If a child becomes disabled before the maximum age and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse.

In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**

How to enrol
For you – You must provide the proper enrolment information to Sun Life through your employer.
For a dependent – You must ask for dependent coverage.

You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health.
- Employee Optional Life
- Spouse Optional Life
- Child Optional Life
- Employee Optional Critical Illness
- Spouse Optional Critical Illness
- Child Optional Critical Illness
- Long-Term Disability

When coverage begins
Your coverage begins **on the later of** the following dates:
- the date you become eligible for coverage.
- the date Sun Life approves your proof of good health, if required.

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

A dependent's coverage begins **on the later of** the following dates:
- the date your coverage begins.
- the date you first have a dependent.

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

Changes affecting your coverage
If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.

If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

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

Updating your records
To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:
- change of dependents.
- change of name.
- change of beneficiary.
- change of address.

Accessing your records
You may request copies of your records, including:
- your enrolment form or application for insurance.
- any written statements or other record about your health that you provided to Sun Life in applying for coverage.
- one copy of the insured contract.

We will not charge you for the first copy but we may charge a fee for further copies.

Need a copy of a document? Contact one of the following:
- our website at www.mysunlife.ca.
- our Customer Care centre, toll-free at 1-866-896-6984.

When coverage ends
As an employee, your coverage will end on the earlier of the following dates:
- the date your employment ends or your 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 end of coverage may vary from benefit to benefit. For infomation about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

Legal actions

Limitation period for Ontario:

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

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

Proof of disability

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

Medical examination

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

Recovering overpayments

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

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

Assignments

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

Definitions

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

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

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.

Long-Term Disability

General description of the coverage

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

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

For the purposes of your Long-Term Disability coverage:

- during the first 104 weeks (this period is known as the **own job period**), we consider you to be totally disabled while you are continuously unable due to an illness to perform the usual duties of your job.
- afterwards, we will consider you to be totally disabled while you are continuously unable due to an illness to perform any occupation, for any employer, for which you are or may become reasonably qualified by education, training or experience and that provides you with an income equal to or greater than the amount of monthly disability benefits.

The availability of work with any employer does not affect the determination of total disability.

We pay these benefits at the end of each month. We base them on your coverage on the date you became totally disabled.

When disability payments begin
Your Long-Term Disability payments begin **on the later of** the following dates:

- after you have been totally disabled for the uninterrupted period indicated in the Benefit Summary.
- after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan.

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

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 the maximum amount indicated in the Benefit Summary.
Step 2: We subtract any benefits or payments provided under:

- any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan, excluding any benefits or payments on behalf of a dependent, for the same or a subsequent disability.
- any Workers' Compensation Act or similar law for the same or a subsequent disability.
- a motor vehicle insurance plan.
- a group plan, including any coverage you have because you are a member of an association but excluding any benefits or payments provided under a Critical Illness plan.
- a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- the Québec Parental Insurance Plan.

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

Take the result you got in Step 2, add the above sources of benefits and payments plus the other sources of benefits and payments listed below and check the total you get. If it’s more than 100% of your basic earnings when your disability began, we will reduce your Long-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Other sources of benefits and payments:
- any Workers' Compensation Act or similar law for another disability.
- any Criminal Injuries Compensation Act or similar law.

Benefits or payments from the following sources will not reduce the monthly disability benefit:
- a policy which is solely an individual disability policy.
- a disability attachment to an individual life insurance policy.

Important to remember:
- 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.

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 (reoccurs) due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 3 months of the end of your previous disability.

We will base these benefits on your coverage as it existed on the original date you become totally disabled.

Rehabilitation / Partial disability program

Sun Life may require you to participate in a partial disability or rehabilitation program that we have approved in writing.

This may include one or more of the following:
- consulting our rehabilitation specialist,
- part-time work,
- working in another occupation or vocational training to help you become capable of full-time employment.

During your rehabilitation program, you may receive Long-Term Disability payments plus income, benefits and payments from other sources.

However, the Long-Term Disability payments will be reduced by 50% of the income you receive under the rehabilitation program. If during any month the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began, indexed for inflation, your Long-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

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

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

If you recover damages from another person

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

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

For disability benefits paid or payable prior to the date of trial or settlement, 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. For disability benefits payable after a settlement or trial, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits. Refer to your group contract for more information.

What you are responsible to do

During your total disability, you must make reasonable efforts to do all of the following. If you do not, Sun Life may hold back or discontinue benefits.

- 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 job during the first 104 weeks of total disability.
- receive training to qualify for another occupation if it becomes apparent that you will not be able to return to your job within the first 104 weeks of total disability.
- try to get work in another occupation after the first 104 weeks of total disability.
- obtain benefits that may be available from other sources.

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 end of the maximum benefit period indicated in the Benefit Summary.
- the day 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.

When coverage ends

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

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- 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.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay benefits for total disability resulting from:

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

- cosmetic medical or surgical services, except if the cosmetic services are provided as the result of an accident occurring while you were covered under this contract.

Waiver of premium

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

Critical Illness

General description of the coverage

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

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

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

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

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

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

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

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

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

Specialist physician
Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has

been certified by a speciality examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

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

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

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

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

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

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

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

- employees who are actively at work;
- dependents who are not hospitalized (other than newborn children); and
- persons already having Critical Illness coverage

on the date that the change occurs. The effective date of coverage for the new covered conditions is the date of the change to the plan.
If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions. If a dependent is hospitalized when the change occurs (other than a newborn child), the change will take effect when the dependent is discharged and resumes normal activities and such date will be the dependent’s effective date of coverage for the new covered conditions.

In all instances, we will:

- apply the effective date of coverage to determine a person's eligibility for a Critical Illness benefit payment; and
- apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where:
  - proof of good health was previously required for a person's coverage; or
  - the *Child moratorium* period exclusion previously applied or the child was born or adopted later than 10 months after the date the employee became covered for Child Critical Illness.

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

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

- the new plan, including coverage for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all employees and dependents on the effective date of this plan, regardless of whether the employee is actively working or the dependent is hospitalized on such date;
- for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of coverage is the effective date of this plan; and
- for Critical Illness conditions under this plan which were also covered under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of coverage is the date the person most recently became covered under the previous carrier's plan.

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

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

Covered conditions for employees, spouses and children
We provide coverage for any illness, disorder or surgery that is defined below:

Aortic surgery
Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

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

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

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

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

Bacterial meningitis

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

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

Benign brain tumor

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

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

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

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

Moratorium Period Exclusion:
If, within 90 days following the later of:

- the date a person enrols for any amount of coverage; or
- the effective date f such amount of coverage,

the covered person has any of the following:

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

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

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

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

Blindness

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

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

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

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

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

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

No benefit will be payable under this condition for the following:
- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Moratorium Period Exclusion:
If, within 90 days following the later of:
- the date a person enrols for any amount of coverage; or
- the effective date of such amount of coverage,

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

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

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

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

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

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

Coma

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

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

Exclusions:
No benefit will be payable under this condition for:

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

Coronary artery bypass surgery

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

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

Deafness

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

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

Dementia, including Alzheimer's disease

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

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

The covered person must exhibit:

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

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

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

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

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

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

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

Exclusions:
No benefit will be payable under this condition for:

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

Heart valve replacement or repair
Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

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

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

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

Loss of independent existence

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

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

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

Loss of limbs

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

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

Loss of speech

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

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

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

Major organ failure on waiting list

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

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

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

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

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

Motor neuron disease
Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

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

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

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

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

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

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

- the date a person enrols for such amount of coverage; or
- the effective date of such amount of coverage.

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

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

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

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

Exclusions:
No benefit will be payable under this condition if:

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

Paralysis

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

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

Parkinson's disease

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

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

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

Moratorium Period Exclusion:
If, within 1 year following the later of:

- the date a person enrols for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

Severe burns

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

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

Stroke (cerebrovascular accident)

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

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following date of diagnosis.

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

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

Exclusions:

No benefit will be payable under this condition for:

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

Covered conditions for children only

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

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

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

For children:

- who are your children or your spouse's children and are born during the period beginning 90 days prior to the date you become covered for Child Critical Illness and ending 10 months after such date, the Child moratorium period exclusion applies.
- who are your children or your spouse's children and are born or adopted later than 10 months after the date you become covered for Child Critical Illness, neither the Child moratorium period exclusion or the Pre-existing conditions provision apply.
- other than those described above, the Pre-existing conditions provision applies unless proof of good health is required for the child's coverage.

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

References to a covered person include children.

Cerebral palsy

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

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

Congenital heart disease

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

Covered heart conditions:

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

The diagnosis of the heart condition must be:

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

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

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

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

Procedures not covered by this definition are:

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

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

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

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

Cystic fibrosis

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

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

Down's syndrome

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

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

Muscular dystrophy

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

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

Type 1 diabetes mellitus

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

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

What is not covered

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

No benefits are payable for claims resulting directly or indirectly from any of the following:
- intentionally self-inflicted injuries or attempted suicide, while sane or insane.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol.

Child moratorium period exclusion

Any child of yours or your spouse will be excluded from Critical Illness coverage if:
- that child was born within the 90 day period prior to the date you obtain Child Critical Illness coverage; or,
- that child is born on or within 10 months after the date you obtain Critical Illness coverage for your existing children,

and, before or within 90 days after that child's birth:
- that child is diagnosed with any covered condition; or,
- that child has any signs, symptoms or investigations that lead to a diagnosis of a covered condition within 5 years of the child's birth.

Pre-existing conditions

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

no benefits are payable for any covered condition that results from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person, during the 12 months prior to the effective date of such amount of coverage:
- had signs, symptoms, consulted a physician or other health care practitioner; or
- was provided any health-related care, advice or treatment; or
- would have consulted a physician or other health care practitioner, acting as a reasonably prudent person with such injury, sickness, medical condition, signs or symptoms.

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

This exclusion does not apply where the *Child moratorium period exclusion* applies or to any child of the employee or the employee's spouse who is born or adopted later than 10 months after the date the employee becomes covered for Child Critical Illness.

Portability

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

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

At the time that you and/or your spouse apply to transfer group Critical Illness coverage to another critical illness policy, you or your spouse may also apply to transfer the group Critical Illness coverage for any

covered children. We will not require the child's proof of good health. However, if either you or your spouse maintain coverage under this plan, the Critical Illness coverage for the child cannot be transferred.

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

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

Best Doctors

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

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

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition, even if it is not a covered condition under this Critical Illness benefit. To learn more about Best Doctors services, or to use these services, please call Best Doctors at 1-877-419-BEST (2378).

Liability and responsibility of Sun Life

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

Sun Life cannot guarantee the availability of Best Doctors services.

Life Coverage

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

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

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

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

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

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

Fact
If you designated a beneficiary under a previous group plan of the employer, Sun Life will apply and carry it forward to your coverage under this plan until you change it.

There are different rules for designating a minor beneficiary, please refer to your contract for specific information.

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

Coverage during total disability
Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 65, whichever is earlier, as long as you are totally disabled, but not beyond age 65. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact your employer for details.

Converting Life coverage

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

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

The request must be made within 31 days that the Life coverage reduces or ends.

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

Benefits Insured by AIG Insurance Company of Canada

The wording in this section has been provided by AIG Insurance Company of Canada, who assumes sole responsibility in the case of any discrepancies between this wording and the policy issued by them.

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial re- sources to fulfill their financial responsibilities.

Your Employer has provided you with Accident Insurance coverage under- written by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance or loss of use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a Principal Sum amount equal to your group plan member Basic Life insurance.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock— at work, at home or at play, anywhere in the world.

Definitions

"Insured Employee" means you, if you are an employee of the Policyholder who is under the age of 70, and belong to an eligible class of employees.

Eligible Dependents:
"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

"Dependent Child" means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your employer's current group life policy. If there is no written designation, then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of Losses

Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of entire sight of both eyes	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of one hand and the entire sight of one eye	The Principal Sum
Loss of one foot and the entire sight of one eye	The Principal Sum
Loss of one arm or one leg	Four-fifths of the Principal Sum
Loss of one hand or one foot	Three-quarters of the Principal Sum
Loss of the entire sight of one eye	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand	One-third of the Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of speech or hearing	Three-quarters of the Principal Sum
Loss of hearing in one ear	Two-thirds of the Principal Sum
Loss of four fingers of one hand	One-third of the Principal Sum
Loss of all toes of one foot	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands	The Principal Sum
Loss of use of one hand or one foot	Three-quarters of the Principal Sum
Loss of use of one arm or one leg	Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs)	Two times The Principal Sum up to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times The Principal Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to "Quadriplegia", "Paraplegia", and "Hemiplegia" means the complete and irreversible paralysis of such limbs; "Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; "Arm" or "Leg" means the complete severance through or above the elbow or knee joint;
"Thumb and Index Finger" means the complete severance through or above the first phalange; "Fingers" means the complete severance through or above the first phalange of all Four Fingers of One Hand; "Toes" means the complete severance of both phalanges of all the Toes of One Foot; "The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; "The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20

degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Rehabilitation Benefit
Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within three years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit
Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and re- quire a wheelchair to be ambulatory.

Workplace Modification and Accommodation Benefit
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.

Psychological Therapy
Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit
Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation
Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 150 kilometres from home.

Repatriation Benefit
Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit
Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit
Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.

Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

Waiver of Premium
Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage
Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit
If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt there at by you while sane;
(b) self inflicted injury or any attempt there at by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) injury sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
    (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    (iii) riding as a passenger in an aircraft owned or leased by the Policyholder;

(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full- time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date under the Basic Accident Insurance:

Your coverage begins on the date you satisfy the definitions of “Insured Employee”.

Effective Date under the Voluntary Accidental Insurance:

Coverage for an Insured Employee, Spouse, or Dependent Child begins on the latest of: (1) the policy effective date; (2) the first day of the month following receipt of your completed application by your Human Resources Department; or (3) the date such person satisfies the definition of “Insured Employee”, “Spouse” or “Dependent Child”.

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the date you no longer satisfy the definition of an Insured Employee; or
   the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

Hopital Montfort

POLICY NUMBER
CMG 9428930

July 2022

EMERGENCY OUT-OF-PROVINCE MEDICAL COVERAGE

Each Canadian province provides a provincial medical plan with comprehensive benefits for hospital confinement, the service of medical doctors and other health practitioners, ambulance services, etc. In many cases, the benefits provided by these plans will pay all, or almost all, of the expenses you incur in your home province. (Note: In this Plan, "province" also refers to a "territory" of Canada, where applicable; "you" and "your" includes the Insured Members and their eligible dependents.)

When you are outside your province of residence and require these services, your provincial medical plan will usually make a payment towards your expenses; but that payment is usually limited to the amount that would have been paid for the same service in the province in which you reside. Unfortunately, there is often a considerable difference between the cost of these services outside your province of residence and the amount allowed by your provincial medical plan, which you would have to pay yourself were it not for this valuable benefit.

This Plan provides extensive coverage for many services rendered outside your province of residence. It is important to note that such expenses are covered provided that they were unexpected and of an emergency nature.

ELIGIBILITY

All Insured Members and Retirees under the Hopital Montfort and their eligible dependents whose names are on file with the Policyholder are insured under this Plan.

Class I: All active Employees under age 70.
Class II: All active Employees over age 70.
Class III: All eligible Retirees under age 65.

PERIOD OF COVERAGE

You and your dependents are covered while outside your province of residence for such reasons as business or vacation. Expenses incurred by you are not covered in the event that you had left the province for the purpose of obtaining medical treatment, (except as indicated under the Referral Services benefit).

Trips are limited to 180 consecutive days – Classes I and II
Trips are limited to 30 consecutive days – Class III

EMERGENCY COVERAGE FOR HOSPITAL, MEDICAL AND THERAPEUTIC SERVICES OUTSIDE PROVINCE OF RESIDENCE

When injuries or sickness result in emergency hospitalization, medical or therapeutic services, the Company will pay benefits for the period this contract is in force, not to exceed the maximum benefit amount shown below for the actual expenses incurred outside your province of residence that exceed the amount which is payable with respect to such expenses under any government hospitalization or medical care plan in your province of residence (GHIP), or if you are not covered under any such plan, to the extent that they exceed any amount which would be payable with respect to such expenses under the provincial medical plan if you were covered under any such plan.

Benefit Maximum amount reduces as follows:

Under age 70 - $5,000,000.00 lifetime maximum
Age 70 to 74 - $2,000,000.00 lifetime maximum
Age 75 and over - $1,000,000.00 lifetime maximum

HOSPITAL CONFINEMENT

Benefits are payable for confinement as a resident in-patient in a hospital, including semi-private accommodation and charges made by the hospital for services and supplies rendered by such hospital and provided for use during such confinement.

In the event that you are confined to hospital at the end of your trip outside Canada and thus prevented from returning to Canada, insurance will continue for the period of such confinement, but in no event for more than 12 months from the date the first insured expense was incurred.

MEDICAL AND THERAPEUTIC SERVICES:

Benefits are payable for:

a) the services of a legally qualified physician or surgeon (other than an insured person);

b) laboratory tests and X-ray examination by a legally qualified doctor of medicine for the purpose of diagnosis;

c) the services of a registered graduate nurse (other than a relative by blood or marriage), up to a maximum of 50 nursing shifts at the usual and customary fee, but not more than $100 per shift;

d) rental of crutches or hospital type bed, or the cost of splints, canes, slings, trusses, braces or other approved prosthetic appliances;

e) the services of a legally qualified anaesthetist;

f) drugs or medicines that require a legally qualified physician's written prescription;

g) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist (other than a relative) up to a maximum of $300 per practitioner;

h) expenses for accidental injury to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires treatment by a legally qualified dentist or dental surgeon within 30 days from the date of the accident, not to exceed in the aggregate the amount of $2,000 as the result of any one accident;

i) expenses for the relief of dental pain, other than pain caused by an accident, initiated within 48 hours of the onset and completed no later than 90 days after initial treatment, not to exceed $500; and

j) out-patient services provided by a hospital.

AUTOMOBILE RETURN

If you become totally disabled and you are unable to continue your trip or vacation, the Company will pay the actual charges of a commercial agency for the return of your private or rental vehicle used for the trip, to your place of residence or nearest rental agency, up to a maximum of $4,000.

"Totally Disabled" means your complete inability, on medical evidence, to continue your duties or activities and to continue your trip or vacation.

REPATRIATION BENEFIT

When injuries or sickness covered by this Plan result in your loss of life in a province or country other than your place of residence and within 365 days after the date of the incident, the Company will pay the actual expense incurred for preparing your body for burial or cremation and shipment of your body to your place of residence in Canada, the amount not to exceed $15,000.

IDENTIFICATION BENEFIT

If your body requires identification following your loss of life for which a benefit is paid or payable hereunder, the Company will pay to one of your Immediate Family members, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of 3 consecutive nights); and

b) transportation by the most direct route to such location.

This benefit is payable by the Company only if the body is located outside the Immediate Family member's normal province of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.40 per kilometre travelled.

The maximum amount payable for this benefit is $5,000 per Insured Person.

TRIP INTERRUPTION BENEFIT

If your scheduled departure is delayed for at least 12 hours due to sickness or hospitalization as provided by the Plan, or due to sickness or hospitalization of your covered travelling companion, the Company will reimburse you up to a maximum of $500 for the extra cost of your one-way economy/charter air fare via the most cost-effective itinerary to your next scheduled travel destination or original departure point of the same trip.

The Company will also reimburse the additional and unplanned hotel and meal expenses, telephone calls and taxi fares up to a combined maximum of $300 per day to a maximum of 5 days.

In order to claim any of the above outlined expenses, original itemized invoices must be provided at time of claim. The combined maximum amount payable for this benefit is $2.000 per Insured Person per incident.

FAMILY TRANSPORTATION BENEFIT

If you suffer injury or sickness, resulting in being confined to a hospital located outside your province of residence, the Company shall pay the reasonable and necessary expenses actually incurred for the transportation of an Immediate Family member to the hospital.

This benefit is only payable if:

a) confinement to hospital occurs within 365 days of the sickness or the accident causing the injury; and

b) reimbursement of expenses are limited to the cost of one economy class return air fare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such immediate family member.

The maximum amount payable for this benefit for any one sickness, or for all injuries resulting from any one accident, is $15,000 and incidental travel expenses up to a maximum of $200 per day to a maximum of $800 per Insured Person.

RETURN TRANSPORTATION FOR TRAVELLING COMPANION

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the extra cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Travel Companion to Canada.

The maximum amount payable for this benefit for any one trip is $5,000 per Insured Person for the transport of one Travel Companion.

RETURN AND ESCORT OF DEPENDENT CHILDREN UNDER AGE

If you are repatriated to Canada in accordance with the Repatriation Benefit, or return to Canada in accordance with the Ground or Air Transportation benefit, the Company will pay a benefit to you (or your estate) for the cost of a one-way economy air fare transportation on a commercial flight or charter via the most cost effective itinerary to transport your Dependent Children travelling with you on a trip to their home, plus reasonable overnight hotel accommodation and meal expenses and for the services of an attendant to escort your Dependent Children under age 16, if required.

The maximum amount payable for this benefit for any one trip is $5,000 per repatriated or returned Insured Person.

REFERRAL SERVICES

In the event you are referred to a hospital outside your province of residence as a resident in-patient, the Company will pay benefits for reasonable and customary charges for standard ward accommodation and for charges made by the hospital for services and supplies to the extent that such are medically necessary. Coverage shall also include the reasonable and customary services of a physician or legally qualified surgeon.

Prior to the commencement of any referral treatment, written pre-authorization from your provincial medical plan and the Company must be obtained. The government hospitalization or medical care plan in your province of residence (GHIP) may cover most, or all, of these costs. Any referral requires written recommendation from the physician or legally qualified surgeon stating the reason for the referral, and a letter from GHIP outlining their liability. Failure to comply in obtaining pre-authorization will result in non-payment.

The maximum amount payable for this benefit in any consecutive 12 month period is $50,000 per Insured Person.

It is understood and agreed that expenses incurred under the Referral Services provision are not due to an emergency. It is further understood and agreed that exclusion h) is not in effect for expenses incurred under the Referral Services provision.

EMERGENCY TRAVEL ASSISTANCE OFFERS THE FOLLOWING FEATURES:

Travel assistance is provided by Global Excel Management Inc. With centres worldwide they will:

- help locate the most appropriate medical facility for you;
- confirm coverage with AIG Insurance Company of Canada and assure the hospital that you are covered;
- guarantee payment for hospitalization, if necessary;
- arrange for admission to a hospital;
- provide translation services;
- contact your own doctor for recommendations, when required;
- contact your family and employer, when required;
- arrange for/co-ordinate emergency medical evacuation; and
- co-ordinate your return home.

HOW TO CLAIM

If you require emergency medical care or hospitalization, you or someone acting on your behalf should contact Global Excel Management Inc. immediately. If circumstances prevent you from calling Global Excel Management Inc. right away, you should contact them as soon as you can. Global Excel Management Inc. will help ensure that you receive the medical care you need and, if possible, will make claims payment arrangements directly with the hospital or service provider.

If you contact GLOBAL EXCEL MANAGEMENT INC. right away, your claim may be pre-approved so you can avoid having to pay upfront and claim for reimbursement later.

If you are not able to contact Global Excel Management Inc. before being billed for the charges, or if your medical needs are minor in nature (i.e., costing less than $500), it is your responsibility to pay the bill promptly yourself and then submit a claim as soon as you return from your trip. In any case, your claim should be submitted no later than 90 days after the expense was incurred. Global Excel Management Inc. and the insurance company are not responsible for dealing with any payment reminders or collection notices that you receive from medical providers.

To make a claim for out-of-pocket expenses, contact a Global Excel Management Inc. operator at:

From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

Give the operator your name and your Policy Number: CMG 9428930.

The operator will send you a claim form. When you complete the form, provide the patient's name and provincial health plan number and your certificate number. Be sure to attach detailed statements and original receipts showing the services rendered and the charges for each service.

Mail your completed claim form and attachments to:

Global Excel Management Inc.
73 Queen Street
Lennoxville, QC, J1M 1J3

Please make sure you obtain your medical records, statements or detailed receipts at the time of treatment and/or discharge, to submit with your claim. All claims must be submitted to Global Excel Management Inc. as soon as possible, and no later than 90 days after the expense was incurred.

COORDINATION OF BENEFITS

Global Excel Management Inc. will co-ordinate coverages with other policies according to the CLHIA's Coordinating Coverage Guidelines for Out-of- Country/Province Health Care Expenses. The total amount payable from all sources may not exceed the expenses you incurred.

IN AN EMERGENCY, HERE'S WHAT TO DO

Call Global Excel Management Inc. immediately in the event of a serious medical emergency.

Their operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

An operator will ask you the following:

Your name, location and the details or your emergency.
Your Policy Number: CMG 9428930
Service Support Telephone Numbers:

Telephone:
From Canada & U.S., call toll free 1-877-207-5018
Outside Canada & U.S., call collect 1-819-566-3940

GROUND TRANSPORTATION

The use of a licensed ground ambulance to a maximum of $5,000 any one accident or sickness.

AIR TRANSPORTATION

a) If an injury or sickness commencing during the course of your trip results in a medically necessary Air Transportation, the Company will pay benefits for covered expenses up to a maximum of $500,000. An Air Transportation must first be approved by the Company and it must be ordered by a legally licensed physician or surgeon who certifies that the severity of your injury or sickness warrants your Air Transportation and that such is medically necessary.

b) If, due to the geographical area at the onset of your medical emergency an air ambulance is deemed necessary, the Company will pay the cost of a licensed air ambulance for your transport to the nearest hospital or medical facility where appropriate medical treatment can be obtained.

Air Transportation means:

a) your medical condition warrants immediate transportation from the place where you suffered the injury or sickness to the nearest hospital where appropriate medical treatment can be obtained; or

b) after being treated at a local hospital, your medical condition warrants transportation to the place where you reside (provided such residence is located in Canada) to obtain further medical treatment or to recover; or

c) both **a)** and **b)** above.

Covered expenses are only those reasonable and customary expenses, up to the maximum, for transportation, medical services and medical supplies which are medically necessary and incurred in connection with your Air Transportation. All transportation arrangements made for transporting you must be by the most direct and economical route. Expenses for special transportation must be recommended by the attending physician or surgeon or required by the standard regulations of the conveyance transporting you.

Expenses for medical supplies and services must be recommended by the attending physician or surgeon. Air Transportation means any land, water or air conveyance required in connection to transport you during an Air Transportation. Special Transportation includes, but is not limited to, air ambulance, land ambulances, commercial airlines and private motor vehicles.

Charges for use of a local ambulance and/or the use of a scheduled air carrier on physician's advice, up to the cost of a one-way economy air fare for you and $250 for incidental travel expenses; if return by stretcher is required, the cost of such additional economy class seating as is necessary; if a medical attendant is required to accompany you, the Company will pay the fee of such attendant plus one return economy air fare and reasonable incidental travel expenses.

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

a) injuries received while you are participating in any maneuvers or training exercises of the armed forces;

b) pregnancy, miscarriage, voluntary termination of pregnancy, childbirth or their complications except that in the case of a pregnancy, complications which occur before the end of the seventh month will be covered if they occur while insured hereunder;

c) sickness or injury where the trip is undertaken for the purpose of securing medical treatment or advice for such sickness or injury;

d) dental surgery or cosmetic surgery unless such surgery is a result of a covered injury;

e) emotional or mental disorders unless you are hospitalized;

f) sickness or injury due to participation in professional sports;

g) treatment or services that contravene any government hospital or medical plan in Canada;

h) expenses incurred on an elective (non-emergency) basis;

i) loss or injury as a result of suicide or any attempt thereat or self-inflicted injuries while sane or insane;

j) an act of declared or undeclared war, civil war, rebellion, revolution; insurrection, military or usurped power or confiscation or nationalization or requisition by or under the order of any government or public or local authority;

k) any services or supplies provided by an Insured Person;

l) any treatment or surgery not required for the immediate relief of acute pain or suffering;

m) any treatment or surgery which reasonably could be delayed until you return to your province of residence; and

n) anticipated medical treatments required on an ongoing basis or for continued stabilization of a medical condition known to you prior to departure.

o) a medical condition that had deteriorated, or had to be treated or investigated in the three (3) months immediately preceding the Insured Person's departure from Canada. Applicable to Class II only.

All expenses must be incurred on a non-elective emergency basis and are in excess of any individual, group or provincial medical plan.

EXTENDED COVERAGE AFTER TERMINATION

In the event of the delayed arrival of your common carrier hospitalization this Plan will automatically be extended at no charge:

1) 24 hours in the event of a delayed common carrier;

2) the period of hospitalization plus 24 hours after you are released from hospital.

TERMINATION OF COVERAGE

Coverage will terminate on the earliest of:

1) the date you cease to meet the eligibility requirements of the Plan;

2) the date any required premium is unpaid; or

3) the date the Master Policy terminates or in accordance with any other terms and conditions stated in the Master Policy.

WHAT TO DO IN A MEDICAL EMERGENCY

You or someone acting on your behalf should call Global Excel Management Inc. immediately, before you get medical assistance. If you can't call right away, contact Global Excel Management Inc. as soon as you are able to do so.

Call:

U.S. & Canada 1-877-207-5018
Outside U.S. & Canada 1-819-566-3940 collect

The operator will ask you for:

Your name, location and the details of your emergency
Your Policy Number: CMG 9428930

The operators are backed by a team of emergency care professionals - physicians and nurses who work closely with the doctor looking after you, and if necessary, your family or company doctor, to help ensure that you receive the medical care you need.

This brochure has been prepared to help you understand your coverage and, as such, does not create or confer any contractual or other rights. The terms and conditions governing the insurance are set out in the group Master Policy issued by AIG Insurance Company of Canada. In the event of any variation between information in this brochure and the provisions of the policy, the latter will prevail.

AIG

Benefits Administered by Coughlin & Associates Ltd.

Definitions

By spouse/partner, we mean:

- the person to whom you are legally married; or
- the person with whom you have lived in a common-law relationship for 12 consecutive months and whom you have publicly represented as your spouse/partner.

Only one spouse will be eligible for coverage under this program. The same spouse must be insured for all eligible benefits.

By dependant child, we mean:

- an unmarried natural, adopted, or stepchild who is entirely dependent on you for maintenance and support and who is:
    - under 21 years of age who is not employed on a regular full-time basis for more than 30 hours per week; or
    - between 21 years of age and under 25 years of age and attending an accredited educational institution on a full-time basis; or
    - Unmarried child who is incapable of supporting themselves due to a physical or mental disorder and who depends on you for maintenance and financial support, provided the child has been disabled before the limiting age and the disorder has been continuous since that time. Supporting documentation completed by a medical doctor will be required.

Effective Date of Dependant Coverage

Coverage for dependants will go into effect on the latest of the following dates:

- the date your spouse/partner/dependant becomes eligible for coverage;
- the same day you apply for spousal/dependant coverage, provided the application is made within 31 days of the date you first become eligible for coverage. If you do not apply for dependant coverage within the 31-day period, evidence of insurability will be required.

All coverage changes (dependant changes, changing from single to family or family to single, adding or removing dependants, etc.) must be made through your human resources office or the plan administrator.

Comparable Coverage and Late Applicants

You may decline to be covered for certain benefits under this plan in order to be covered as a dependant under a comparable group benefits program. If that coverage ends due to either the termination of the group contract or because you cease to be eligible, you may acquire similar benefits available under this plan, without delay or providing evidence of good health. However, you must apply for such coverage within 31 days of the termination of that comparable coverage, including a change in your family status.

Change in family status means:

- the loss of insurance coverage from a spouse's group insurance plan;
- the addition of a spouse through either marriage or a common-law relationship;
- the divorce, separation or annulment of the person with whom you are married or have a common-law relationship; or
- the birth or adoption of a dependent child.

Applicants who apply for coverage after 31 days of the termination of comparable coverage will be asked to provide evidence of insurability. This means that in order to qualify for benefit coverage, the late applicant must fulfil certain medical standards, as set by the administrator, so as to not pose significant financial risk to the plan sponsor. Your application will be reviewed and coverage may be approved or declined based

on the information provided. Furthermore, the amount payable for all dental services will be limited to $250 for each covered person for the first 12 consecutive months of coverage.

All coverage changes (dependant change, changing from single to family coverage, or family to single, adding or removing dependants, etc.) must be made through your employer or the plan administrator.
All fees charged by medical practitioners for the completion of medical forms or other documentation are the responsibility of the applicant.

Coverage Following the Termination of Extended Health and Dental Care Benefits

If your extended health and/or dental care coverage terminates due to any reason, including termination of your employment or retirement, you and your dependants may be eligible for similar coverage under an individual policy, without providing evidence of insurability. You must apply for such coverage within 60 days of the termination of your coverage under this policy. Other coverage options may also be available.

Please contact the plan administrator for further information.

Coordination of Benefits (COB) Guidelines

If you or your dependants are also covered under another health insurance program or contract, the payment of your benefits will be coordinated so that the total benefit you will receive will not exceed 100% of allowable expenses.

Subject to the consent of the covered person, the plan administrator may release to any person or corporation any data necessary to implement this provision.

Order of Benefits Determination

If you or your dependants are eligible to receive a payment under this contract and a similar payment under another benefits plan, the payment of benefits to you will follow this order:

- if the other plan does not have a COB provision, the benefits of the other plan will be paid first;
- if the other plan contains a COB provision, its benefits will be coordinated with those under this agreement so that priority will be given to the plan under which the person is eligible to receive benefits as follows:
    - other than as a dependant;
    - as a dependent child of the parent with the earlier month and day of birth in the calendar year;
    - as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

In cases of separation or divorce:

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

If the person is covered under another plan, priority will go to:

- the plan where the employee is an active, full-time employee;
- the plan where the employee is an active, part-time employee;
- the plan where the employee is a retiree.

If priority cannot be established according to the above, the benefits shall be paid under both plans in a ratio proportionate to the amounts that would have been paid under each plan had there been coverage under just that plan.

Extended Health Care Benefit

Plan members must be covered under their provincial health care plan to be eligible for this benefit.

If, while insured, you or your dependants incur any of the eligible expenses for medically necessary services or supplies in the treatment of an illness or injury, the plan will pay a benefit subject to the extended health care limitations. The amount payable will be determined based on the percentage and maximums shown in the *Benefits Summary.*

For benefits where no maximum is indicated, reimbursement will be limited to the reasonable and customary cost of that product or service.

Reasonable and customary treatment means that the treatment provided is accepted by the appropriate Canadian medical profession as being proven scientifically and effective medically and of a form, intensity, frequency and duration deemed necessary and relevant for the diagnosis and management of the illness or injury, subject to the limits specified in the *Benefits Summary.*

Reasonable and customary charges considered under this plan means charges for services whose nature and severity are in accordance with the fee practices and tariffs of the official fee schedule for the profession, or if there is no official fee schedule, representative fee practices and tariffs of the profession in the area.

Calendar year means the period from January 1st to December 31st inclusively.

Prescription Drugs

Drugs, serums, compound mixtures, and injectables, including oral contraceptives, only available by prescription, when prescribed by a medical doctor within the terms and regulations governing that profession, or dentist.

Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to the maximum specified in the *Benefits Summary.*

Diabetic supplies such as diabetic needles, syringes and test strips.

Viscosupplementation devices are eligible up the limitation listed in the *Benefits Summary.*

Brand name drugs are eligible up to the price of the generic drug equivalent.

Certain eligible medications may require the prior authorization of the plan administrator.

Compound mixtures, when at least one ingredient is a prescription requiring medication, are eligible under the plan.

Hospital Care

The plan will cover the costs for hospital care in the province where you live, up to the cost of accommodation listed in the *Benefits Summary.*

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

If the plan member is confined in a chronic hospital or chronic care unit of a public general hospital, reimbursement will be made up to the maximum indicated in the *Benefits Summary.* Benefits are not payable for accommodation in psychiatric hospitals or nursing homes.

Vision Care

Reimbursement of eligible eye wear is based on the date the items are paid in full. A written prescription by a licensed or registered optometrist or ophthalmologist is required. Reimbursement for eye exams is based on the date of the eye exam.

The plan will also cover contact lenses that are prescribed because the regular surface of the lens of the eye (the cornea) is impaired in some way and visual acuity cannot be improved to at least a 20/40 level in the better eye with ordinary eyeglasses.

Paramedical Services

Medically necessary services, including X-rays, of licensed, certified or registered (in the province where treatment is given) paramedical practitioners up to reasonable and customary fees per visit when operating within their recognized fields of expertise to the maximums specified in the *Benefits Summary.* Reimbursement is based on the dates the services were rendered. All receipts must clearly indicate the names of those attending the sessions.

If you choose to enter into a block payment or annual payment plan for services, reimbursement will be made at the end of the contract period, upon submission of all receipts and a copy of the contract.

Medical Services and Supplies

The plan will cover the costs after provincial plan coverage (if applicable) for the medical services listed below when ordered by a doctor, up to the maximums indicated in the *Benefits Summary.* If no maximum is indicated, reimbursement will be based on the reasonable and customary costs in the locality where the services and supplies were provided. Reimbursement of eligible items is based on the date the items are paid in full.

- Hearing aids or repairs to existing hearing aids. Hearing aid evaluation tests, ear examinations, initial batteries at the time of purchase, and replacement batteries are not eligible.

- Custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).

- Custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist (must indicate medical diagnosis).

- Private duty nursing 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 cannot perform the duties. A pre-care assessment must be provided and prior authorization by the plan administrator is required.

- External breast prosthesis (following mastectomies) and surgical brassieres.

- Wigs for patients who have undergone special treatment, such as chemotherapy. A doctor's referral indicating the condition being treated is required.

- Transcutaneous electric stimulators (TENS) machines. A doctor's referral indicating the condition being treated is required.

- Transportation in a licensed ground or air ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.

- Rental or at the administrator's discretion, purchase of durable equipment including but not limited to standard-type wheelchair, wheelchair repairs, hospital bed (with or without mattresses), hospital bed rails, respirator/ventilator, oxygen and its administration, apnea monitors. In lieu of rental, the plan may, at its discretion, substitute charges for the purchase of such articles where applicable rental charges will be applied to the purchase price.

- Rental or at the administrator's discretion, purchase of braces, trusses, casts, canes, crutches, walkers, splints (excluding dental splints), cryocuffs, cervical collars, standard-type artificial limb or eye. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities, with the written prescription of a physician.

- Purchase of colostomy and ileostomy supplies (where surgical stoma exists), payable after incurred expenses exceed the provincial health plan.

- Laboratory tests performed by a commercial laboratory for the diagnosis of an illness.

- Medical services and supplies including bandages, surgical dressings, blood transfusions, plasma, radium and radioactive isotope treatments when authorized by the patient's attending physician.

- Certain diagnostic laboratory services and X-rays, except for those provided by a doctor in the course of treatment and not normally covered by the provincial health care plan.

- The costs of treatment for the repair or replacement of natural teeth, which require treatment as a result of accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective date of the plan. Treatment must be completed within 12 months of the date of the accident. Reimbursement will be based on the current Dental Association fee guide for general practitioners, denturists or specialists in the province of residence in effect at the time of the treatment.

Out-of-Province/Canada Referral Treatment

Eligible expenses incurred outside the province of residence of the insured person as a result of a referral include the following provisions:

1) This service or treatment must not be available in Canada or in the normal province of residence of the insured person;

2) The insured person must provide the insurer with a letter of referral from a physician in his normal province of residence, indicating that he is being referred to another physician;

3) The insurer must give prior written approval;

4) The provincial health and/or hospital insurance plans must pay a portion of the eligible expenses.

The maximum amount payable by the insurer under this provision is limited to the percentage specified in the *Benefits Summary.*

Expenses Not Covered

- Services covered by any provincial government plan or any workers' compensation board.
- Any care, services or supplies that are not medically necessary, as determined by the plan administrator.
- Services or supplies to the extent that their costs exceed the reasonable and customary rates in the locality where the services or supplies are provided.
- Care, services or supplies utilized as treatment of lifestyle choices, as determined by the plan administrator.
- Services or supplies that are primarily for cosmetic purposes.
- Drugs or medicines, services or supplies that have been self-prescribed, or prescribed by or for family members.
- Drugs, injectables, supplies or appliances that are experimental or that are not approved by Health Canada.
- Vitamins unless they are injected, vitamin preparations, food supplements, and drugs not approved for sale in Canada.
- Charges incurred as a result of conditions arising from war, whether or not war was declared, from participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Vision care expenses for magnifying glasses or safety glasses of any kind.
- Additional, duplicate or replacement appliances or devices, except where the replacement is required because the existing appliance can no longer be made serviceable due to normal wear and tear, or as the result of a pathological change, unless prior approval in writing is obtained from the plan administrator.
- Vaporizers, breast pumps and nebulizers.
- Convalescent hospital.
- Palliative care.
- Rehabilitation centre.
- Charges incurred as a result of self-inflicted injury or while committing, or attempting to commit, a criminal offence.
- All fees charged by medical practitioners for the completion of medical forms or other documentation or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.
- The plan will not pay for the following, even when prescribed:
    - the cost of giving injections, serums and vaccines
    - medicines obtained from dentist
    - treatments for weight loss, including drugs, proteins and food or dietary supplements
    - hair growth stimulants
    - contact lens care products and eye lubricant
    - dietary supplement, diet foods, vitamins, vitamin supplements, minerals other than hematinics, and anorexiants
    - food and food products including infant formula, infant foods, salt and sugar substitutes
    - skin and hair care products, including protectives, soaps, cleansers, emollients, lubricants, suntan lotions and deodorants
    - personal hygiene products, contraceptive preparations and devices
    - dental and oral hygiene products, including toothpastes, mouthwashes, and prophylaxis treatments
    - lozenges and cough suppressants or antacids, anti-flatulents and absorbents
    - medications for pets
    - laxatives, anti-diarrheals and hemorrhoidals
    - drugs listed as excluded in the *Benefits Summary*

Dental Care Benefit

If, while insured, you or your dependants incur any of the eligible expenses for dental services, the plan will pay a benefit subject to the dental care limitations. The amount payable will be determined based on the percentage shown in the *Benefits Summary.*

Benefits are based on current Dental Association fee guide for general practitioners, denturists or specialist indicated in the Benefits Summary.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided.

Pre-determination of Benefits/ Treatment Plan

Where a course of treatment is expected to cost $500 or more, it is recommended that the insured person obtain a written estimate outlining the procedures and itemized charges, including X-rays, from the attending dentist. The estimate should be submitted to the plan administrator prior to commencement of the treatment. The plan administrator will review the estimate and advise the insured person on the amount of benefit payable.

Alternate Benefit Provision

Situations may arise where alternative methods of treatment may be available. It is solely for the member and his/her dentist to decide which method will be employed. As the basis for determining liability under the benefit plan, the administrator reserves the right to use the least expensive method of treatment that would provide a professionally adequate result.

This provision cannot be applied on excluded provisions, services or devices.

Basic Services

Examinations

- Complete oral examination, according to the frequency specified in the *Benefits Summary*
- Recall oral examination, according to the frequency specified in the *Benefits Summary*
- Specific oral examination, according to the frequency specified in the *Benefits Summary*
- Emergency oral examination, according to the frequency specified in the *Benefits Summary*

Diagnostic services

- Radiographic examination and complete intra-oral film series, according to the frequency specified in the *Benefits Summary*
- Periapical films, according to the frequency specified in the *Benefits Summary*
- Occlusal films
- Posterior bitewing films, according to the frequency specified in the *Benefits Summary*
- Extra-oral films
- Panoramic films, according to the frequency specified in the *Benefits Summary*
- Cephalometric films
- Tracing and interpretation of radiographs from another source

Preventive services

- Polishing, according to the frequency specified in the *Benefits Summary*
- Fluoride treatment, according to the frequency specified in the *Benefits Summary*
- Oral hygiene instruction, according to the frequency specified in the *Benefits Summary*
- Interproximal discing of teeth
- Finishing restorations
- Pit and fissure sealants, according to the frequency specified in the *Benefits Summary*
- Space maintainers, according to the frequency specified in the *Benefits Summary*
- Prophylactic odontotomy/enameloplasty

Restorative services

- Non-bonded amalgam restorations for primary teeth, permanent anterior and bicuspid teeth, permanent molar teeth
- Caries/trauma/pain control
- Tooth-coloured restorations, primary and permanent teeth (including acid and non-acid etching)
- Pin reinforcement
- Acrylic or composite restorations, according to the frequency specified in the *Benefits Summary*
- Prefabricated post and core
- Stainless steel/plastic full coverage restorations for primary teeth
- Preformed stainless steel and polycarbonate crowns, according to the frequency specified in the *Benefits Summary*

Endodontic services

- Pulpotomy
- Root canal therapy
- Apexification
- Periapical services (apicoectomy / apical curettage, retrofilling)
- Root amputation
- Surgery: endodontic exploratory
- Perforations/restorative defect, pulp chamber repair, root repair, non-surgical and surgical
- Isolation of endodontic tooth/teeth
- Hemisection
- Chemical bleaching of endodontically treated tooth/teeth
- Intentional removal, apical filling and re-implantation
- Emergency procedures
- Replantation (excluding root canal therapy and surgery)
- Re-positioning of traumatically displaced tooth/teeth

Periodontal services

- Periodontal scaling and root planing
- Gingivectomy
- Flap approach with osteoplasty/osteotomy
- Flap approach with curettage, according to the frequency specified in the *Benefits Summary*
- Distal wedge procedure
- Osseous grafts
- Soft tissue grafts (free connective tissue grafts)
- Vestibuloplasty (oral manifestations / oral mucosal disorders)
- Post-surgical treatment

Adjunctive periodontal services

- Provisional splinting – intra-coronal, extra-coronal per unit of time
- Occlusal equilibration, according to the frequency specified in the *Benefits Summary*
- Special periodontal appliances, including occlusal guards and bruxism appliances, according to the frequency specified in the *Benefits Summary*
- Maintenance, adjustments and repairs to periodontal appliances, according to the frequency specified in the *Benefits Summary*

Surgical services

- Removal of erupted tooth (uncomplicated)
- Removal of each additional tooth in the same surgical site
- Removal of erupted tooth (complicated)
- Removal of impacted tooth
- Removal of residual roots
- Surgical exposure of tooth
- Surgical repositioning of tooth
- Alveoloplasty
- Gingivoplasty and/or stomatoplasty
- Excision, removal of bone
- Surgical excision (cysts and neoplasms)
- Surgical incision
- Frenectomy
- Miscellaneous surgical services

Anaesthesia

- In relation to covered procedures, according to the frequency specified in the *Benefits Summary*

Professional visits

- Periodontal services post-operative visits, according to the frequency specified in the *Benefits Summary*

Adjunctive general services

- Drugs (injections)

Repairs and rebasing

- Denture adjustments including minor adjustments, according to the frequency specified in the *Benefits Summary*
- Denture repairs and additions
- Denture re-basing and/or re-lining
- Denture, tissue conditioning
- Resetting of teeth

Major Services

Major restorative treatment

Prosthodontic services for the replacement of an existing fixed or removable prosthesis will be considered if one of the following circumstances occurs:

- Replacement is necessitated by the extraction of additional natural teeth
- The existing prosthesis cannot be made serviceable and is in accordance with the frequency specified in the *Benefits Summary*
- The existing prosthesis is temporary and is replaced with a permanent one within 12 months

Prior extraction clause

Prosthodontic services for a fixed or removable prosthesis are covered when they are required to replace a natural tooth or teeth extracted after the effective date of coverage.

Dental implants

Dental implants and related services are covered.

Crowns, inlays and onlays

- Acrylic, processed
- Acrylic, processed to metal
- Acrylic or plastic, transitional, direct (chairside)
- Acrylic or plastic, transitional, indirect
- Porcelain
- Porcelain fused to metal base
- Cast metal post and core as a separate procedure
- Cast metal post and core concurrent with impression for crown
- Pre-formed stainless steel (permanent anterior tooth, permanent posterior tooth)
- Pre-formed plastic (permanent tooth)
- Metal inlay restorations, including temporization
- Metal inlay, three surfaces
- Onlay, per tooth
- Retentive pins in inlays and crowns
- Porcelain inlay/onlay, including temporization

Other restorative services

- Pre-fabricated metal post and core
- Pin reinforced amalgam post and core
- Pin reinforced composite post and core
- Crown made to an existing partial denture clasp (additional to crown)

Prosthodontic services, fixed

- fixed prosthetic evaluation for cases of extensive or complicated restorative dentistry

Prosthodontic services, removable

- complete dentures
- partial dentures
- denture remakes
- immediate complete or partial dentures
- transitional complete or partial dentures

Transitional complete and partial dentures: An existing transitional prosthesis must be replaced with a permanent one within 12 months. Any charges for a temporary prosthesis will be deducted from the cost of the permanent prosthesis at the time of insertion.

Pontics

- Metal cast pontic
- Porcelain fused to metal pontic
- Porcelain pontic, aluminous
- Acrylic processed to metal pontic
- Acrylic pontic processed, transitional during healing
- Acrylic pontic transitional, acid etched to adjacent teeth
- Retainers, inlays and onlays
- Metal inlay
- Metal onlay
- Metal onlay, acid etch bonded

Retainers, crowns

- Acrylic crown, processed, indirect, transitional during healing
- Acrylic crown, direct, transitional during healing
- Acrylic processed to metal crown
- Porcelain crown, aluminous
- Porcelain fused to metal crown
- Metal three-quarter cast crown
- Metal full cast crown
- Retentive pins in abutments

Orthodontic Services

Orthodontic services must be for a treatment that has as its primary objective the correction of malocclusion of the teeth.

An orthodontic treatment plan must be submitted prior to initial claim. Orthodontic fees will be eligible for reimbursement on a monthly basis for the duration of the active treatment, as outlined in the orthodontic treatment plan, and not on the amount or date of the payment, even if treatment is prepaid. The maximum reimbursement for the initial orthodontic payment is 35% of the total cost of the orthodontic treatment.

- services for diagnostic purposes
- preventive orthodontic treatment
- comprehensive orthodontic treatment
- appliances to control harmful oral habits

Expenses Not Covered

- Services, treatments or supplies, eligible under this plan and payable under any government plan, including any no-fault motor vehicle insurance plan.
- Expenses incurred for correction of temporomandibular joint dysfunction (TMJ).
- Expenses incurred as a result of intentionally self-inflicted injuries.
- Charges resulting from committing or attempting to commit a criminal offence.
- Dental care, services or supplies that are primarily for cosmetic purposes.
- Conditions arising from war, (whether declared or not), participation in any civil commotion, insurrection or riot, or while serving in the armed forces.
- Any dental procedure not included in the list of eligible dental services.
- Charges for procedures in excess of those stated in the fee guide as stated in the *Benefits Summary.*
- Services completed after termination of coverage.
- All fees charged by medical practitioners for the completion of medical forms or other documentation or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.

How to Claim Benefits

Life Insurance Claims

In the event of a death, your beneficiary should immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

If the claim is a result of a death: Sun Life must receive the claim form as soon as possible after the death occurred.

For Coverage during total disability: Sun Life must receive the proof of total disability within 12 months of the date the disability begins. After than, Sun Life can require that you provide them with ongoing proof that you are still totally disabled.

There are time limits for making claims. If you do not meet these time limits, you will not be entitled to some or all benefit payments.

Accidental Death and Dismemberment (AD&D) Insurance Claim

In the event of a claim, immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

Long-Term Disability Insurance Claim

In the event of a disability claim, immediately contact your employer who will provide the necessary information.

You should submit your proof of claim at least 8 weeks prior to the completion of your elimination period, but in no event later than 6 months after the end of your elimination period.

If your Long-Term Disability coverage terminates, you must advise Sun Life of the claim within 90 days of the date the coverage terminates.

Sun Life will assess the claim and send you or your employer a letter outlining their decision.

From time to time, Sun Life can require that you provide them with proof of your continued disability. We must be provided with this information within 90 days of the request.

There are time limits for making claims. If you do not meet these time limits, you will not be entitled to some or all benefit payments.

Critical Illness Insurance Claim

In the event of a claim, immediately contact Coughlin & Associates Ltd. who will provide the necessary information.

Initial contact with Sun Life: Within 30 days after the date of diagnosis or surgery.

Proof of claim: Up to 90 days after the date of diagnosis or surgery.

Failure to contact Sun Life or furnish proof of claim withing the above time limits does not invalidate the claim if the contact is made or the proof is given or furnished as soon as reasonably possible, and in no

event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to contact Sun Life or furnish proof within the above time.

There are time limits for making claims. If you do not meet these time limits, you will not be entitled to some or all benefit payments.

Out-of-Province/Canada Group Medical Emergency Insurance Claim

In the event of a claim, immediately contact your carrier who will provide the necessary information.

Your benefit plan provides for direct payment to providers in order to reduce your out-of-pocket expenses. Whenever possible the carrier will arrange for direct billing with providers, and you may choose to assign benefits to the provider of the service (hospital, clinic, physician). To facilitate direct billing be sure to present your medical assistance card to the provider.

Claims you pay out-of-pocket must be submitted directly with all original receipts and a completed claim form including the following information:

1. Your name and complete address;
2. Canadian provincial or territorial Government Health Insurance Plan number with its expiry date or version code (if applicable);
3. Claimant's date of birth, name and, if applicable, relationship to you;
4. Proof of the departure date(s) and return date(s);
5. All original prescription drug receipts (not cash register receipts), and/or itemized bills from the medical provider(s) stating the date(s) of the service(s) provided, the diagnosis, all dates and types of treatment, and the name of the medical facility and/or physician;

Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 12 months of the date of purchase or service. You have 90 days following the termination of your coverage to submit claims for reimbursement.
Interest is not payable on any reimbursement under this plan.

All expenses incurred and paid by the participants will be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

Reimbursement will be made for expenses incurred and paid by a participant for any of the eligible services, substances and appliances set out in and in accordance with, the provisions set forth in the plan group agreement, provided such expenses:

a. are incurred and paid for services, substances and appliances prescribed by, and given under the direction of a physician, subject to the conditions of this agreement; and
b. are in the opinion of the plan administrator reasonable and customary in the area in which they are rendered or supplied.

Reimbursement will not be made for of any eligible expense unless the benefit premiums were paid when due for the months in which the service, substance or appliance was rendered or supplied.

Prescription Drug Card

You can pay for your prescription drugs directly through your drug plan using the all-in-one card.

Your all-in-one card provides your pharmacist with immediate confirmation of covered drug expenses. This means your prescription drug claims will be processed immediately. There are no forms to complete. Simply present the drug card to your pharmacist when purchasing prescription drugs. Payment for your claim will be processed immediately.

The drug card can be used by you as well as your spouse and eligible dependants. It is designed to cover prescription drug costs only and can be used at any pharmacy in Canada.

Member Portal – Electronic Claims

Coughlin & Associates Ltd. offers employees and plan members the option to submit claims for prescription drugs, health and dental online. To access this service, please register at Coughlin's plan member portal members.coughlin.ca or download the mobile app from the App Store or Google Play. Once you are on the portal or have accessed the app:

- Click *Register Account*
- Follow the on-screen instructions and provide your group and certificate numbers, both of which can be found on your all-in-one benefits card.

Once registered, Click Submit a Claim to get started with online claiming.

Pre-Authorized Deposit (PAD)

Pre-authorized deposit is the fastest way for employees and plan members to receive claim reimbursements. Claim reimbursement deposits can be made into your bank account following the approval of your claim and eliminate both the wait for cheques to arrive by mail and the trip to the bank.

To enrol in the PAD program:

- Login to Coughlin's plan member portal
- Click on your profile and select *Direct Deposit.*

Point-of-Service Claims Submission

Claims may also be submitted direct via a point-of-service claims system at approved healthcare providers. Present your all-in-one benefit card to your provider, which will provide them with the following, required information:

Pharmacy :
BIN/Carrier ID #34
Group Number # 59260
Certificate number – printed on your card

Dental:
BIN/Carrier ID #000034
Group Number # 59260
Certificate number – printed on your card

Please note that health and dental claims must be submitted within the time limits specified by your benefit plan.

Submitting Paper Claims

To submit claims by paper/mail, please complete the appropriate claim form and send it, along with any applicable receipts, to Coughlin & Associates Ltd. at the mailing address found below. If your claim includes a coordination of benefits and Coughlin is the secondary payer, please include the original explanation of benefits from the primary insurer, along with photocopies of the original receipts.

Claim forms may be obtained on the Coughlin & Associates Ltd. website, at www.coughlin.ca.

Please note that all claim receipts will be retained by Coughlin & Associates Ltd.. It is therefore recommended that you retain photocopies of receipts for your records.

Dental Care Claims

Coughlin & Associates Ltd. offers electronic submission of dental claims via Electronic Data Interchange. This fast and secure method of claiming allows your claim to be sent directly from your dental office to our claims department for adjudication.

Our EDI service uses the secure data networks of Telus, the dedicated claims processing network sponsored by the Canadian Dental Association. With Telus, you can be assured that the information contained in your dental claim will be transmitted to Coughlin & Associates Ltd. quickly, safely and confidentially right from your dentist's office.

To make use of EDI for dental claim submissions, please present your all-in-one benefit card to your dental provider. You may also contact Coughlin & Associates Ltd. to receive the necessary information.

Claims Appeals Process

In the event a claim is denied and the employee is not in agreement, an appeal may be submitted in writing by the employee to Coughlin & Associates Ltd., identifying the basis of the appeal and including supporting medical information justifying the expense as medically necessary.

These appeals will be reviewed in conjunction with our medical/dental consultants and the decision will be communicated in writing to the employee.

Contact Us

Claims department:
Tel: 613-231-8540
Toll-free 1-877-768-3378
Email: ottclaims@coughlin.ca

All other inquiries:
Tel: 613-231-2266
Toll-free 1-888-613-1234
Fax: 613-231-2345
Email: info@coughlin.ca
Website: www.coughlin.ca

Mailing address:
P.O. Box 3517, Station C
Ottawa, ON K1Y 4H5

Street address:
466 Tremblay Road
Ottawa, ON K1G 3R1

Business hours:
Monday to Friday: 8:30 a.m. to 4:30 p.m. EST