Your Group Insurance Plan

Open Hands
Full-Time Employees

Effective date: November 1, 2023
Publication date: November 15, 2023

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	Appendix
Basic Life, Dependant Life, Optional Life, Spousal Optional Life, Short Term Disability and Long Term Disability (LTD) Insurance	Sun Life Assurance Company of Canada (Sun Life)	50948	Appendix A
Out-of-province/Canada Medical Emergency Insurance	AIG Insurance Company of Canada	CMG 9429097	Appendix B
Extended Health Care and Dental Care	Ottawa Carleton Association for Persons with Developmental Disabilities (OCAPDD) Administered by Coughlin & Associates Ltd.	23111	n/a

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 email at info@coughlin.ca or contact the Ottawa Carleton Association for Persons with Developmental Disabilities 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.

Ottawa Carleton Association for Persons with Developmental Disabilities, 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 Ottawa Carleton Association for Persons with Developmental Disabilities.

As sponsor of the plan, Ottawa Carleton Association for Persons with Developmental Disabilities 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 Ottawa Carleton Association for Persons with Developmental Disabilities, 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 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.

Employee Basic Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	Two times annual basic earnings rounded to the next $1,000.
Non-evidence maximum:	$250,000.
Reduction:	50% reduction to insured amount at age 65.
Termination:	When you reach age 70, or retire, whichever occurs first.

Dependent Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	
• Spouse:	$5,000.
• Child:	$2,500, 24 hours or older.
Termination:	When you reach age 70, or retire, whichever occurs first.

Employee Optional Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	Units of $10,000.
Maximum:	$200,000.
Termination:	When you reach age 65, or retire, whichever occurs first.

Spousal Optional Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	Units of $10,000.
Maximum:	$200,000.
Termination:	When you reach age 65, or retire, whichever occurs first.

Short Term Disability (Weekly Indemnity) Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	66.67% of gross weekly salary to a maximum of $800.
Elimination period:	30 days for accident, 7 days for illness.
Maximum benefit period:	17 weeks.
Tax status:	Taxable.
Termination:	When you reach age 65, or retire, whichever occurs first.

Long-Term Disability (LTD) Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	66.67% of gross monthly salary.
Maximum amount:	$6,000.
Elimination period:	119 days.
Tax status:	Taxable.
Termination:	When you reach age 65, or retire, whichever occurs first.

Out-of-Province/Canada Medical Emergency Insurance

REFER TO APPENDIX B – AIG INSURANCE COMPANY OF CANADA

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses.
Maximum amount:	Under age 70: $5,000,000 lifetime maximum. Age 70 to 74: $2,000,000 lifetime maximum.
Coverage period:	60 consecutive days per trip.
Termination:	Class II: All active Employees ages 70 to 75. Class III: All eligible active non-unionized and Open Hands Employees under age 70.

Extended Health Care Benefits

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum benefit:	Unlimited.
Termination:	When you reach age 70 or retire, whichever comes first.

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

Prescription drugs:

• Deductible:	$2.00 per prescription.
• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Eligible drugs:	All drugs, serums and injectables that are prescribed in writing by a medical doctor or dentist dispensed by a pharmacist, dentist or a physician.
• Drug card:	Yes.
• Maximums and exclusions:	
- Drugs:	Limited to a 34-day supply for prescription drugs or medicines and a 100-day supply for maintenance drugs.
- Sclerosing injections for the treatment of varicosities:	$20 per visit per insured person.
- Viscosupplementation:	Reasonable and customary charges.
- Smoking cessation aids:	Lifetime maximum of $250 per insured person for only items requiring a prescription.
- Sexual dysfunction drugs:	$400 per insured person per calendar year.
- Fertility treatment:	$6,000 per insured person per calendar year.

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

Hospital care:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Coverage:	Cost of a private or semi-private room for each day of hospitalization.
• Palliative care:	Covered under the hospital care coverage as indicated above.
• Convalescent and rehabilitation care:	$20 per day up to 120 days to a maximum of $2,400 per insured person per calendar year.
• Detoxification facility:	$5,000 lifetime maximum per insured person.

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

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum:	$200 per insured person once in any 24 month period for adults and any 12 month period for children under 18.
• Laser eye surgery:	On an ongoing basis up to the maximum listed above.
• Glasses or contact lenses following cataract surgery:	Excluded.
• Artificial crystalline lenses, also known as intraocular lenses (IOL) for cataracts:	Reasonable and customary charges.
• Eye examinations, including eye refraction:	Up to a maximum of $90 per insured person for any period of 12 consecutive months.

Professional and paramedical services:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per practitioner:	
– Acupuncturist:	$500 per insured person each calendar year.
– Audiologist:	$500 per insured person each calendar year.
– Chiropractor:	$500 per insured person per calendar year.
– Christian Scientist:	$500 per insured person per calendar year.
– Dietician:	$500 per insured person per calendar year.
– Massage therapist, kinesitherapist or orthotherapist:	Combined maximum of $500 per insured person per calendar year. Referral required.
– Naturopath:	$500 per insured person per calendar year.
– Osteopath:	$500 per insured person per calendar year.
– Physiotherapist or physical rehabilitation therapist:	Combined maximum of $500 per insured person per calendar year. Rehabilitation therapist must be under physiotherapist supervision. Referral required.
– Podiatrist or chiropodist:	Combined maximum of $500 per insured person per calendar year.
– Psychologist, psychoanalyst or social worker::	Combined maximum of $500 per insured person per calendar year.
– Speech therapist:	$500 per insured person per calendar year.

NOTE: Imaging techniques ordered by a chiropractor, podiatrist, chiropodist or osteopath to a combined maximum of $100 per insured per calendar year.

Medical supplies and services:

• Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per service and/or supply:	
– External breast prosthesis (following mastectomy):	Reasonable and customary charges.
– Surgical brassieres:	Purchase of 2 surgical brassieres per insured person per calendar year.

– Private duty nurse:	$25,000 per insured person each calendar year.
– Artificial eye:	Purchase, including reimbursement for polishing or rebuilding of the artificial eye per insured person up to reasonable and customary charges.
– External prosthetics/artificial limbs:	$5,000 per limb
– Stump socks and other therapeutic devices:	Therapeutic devices combined lifetime maximum of $10,000 per insured person.
– Orthopaedic shoes:	Purchase of one pair insured person per calendar year.
– Custom made orthotics or arch support:	Purchase up to $400 per insured person per calendar year.
– Elastic support stockings:	Purchase of 4 pairs (over 20 mmHg) per insured person per calendar year.
– Conventional wheelchair:	$3,000 per insured person every 60 consecutive months.
– Hearing aids:	Purchase, up to $500 per insured person every 48 consecutive months.
– Diagnostic services:	Reasonable and customary charges.
– Wigs:	$350 lifetime maximum required as a result of chemotherapy. Referral required.
– Glucometer or reflectant meter:	One device per inured person every 48 consecutive months.
– Insulin pumps:	$5,000 lifetime maximum for purchase or repairs.
– Respirators	$10,000 lifetime maximum.
– TENS nerve stimulators:	$700 lifetime maximum. Doctor referral required.
– Intra-uterine device (IUD):	Doctor referral required.
– Out-of province/Canada referral treatment:	$75,000 lifetime maximum per insured person.

Dental Care Benefit

Deductible:	Nil.
Fee guide:	Based on current year Ontario Dental Association fee guide for general practitioners based on the province of residence.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
– Maximum:	Combined maximum with major services to a maximum of $2,000 per insured person each calendar year.
• Major services:	50% of eligible expenses.
– Maximum:	Combined maximum with basic services to a maximum of $2,000 per insured person each calendar year.
• Orthodontic services:	50% of eligible expenses for children under the age of 18.
– Maximum:	$3,000 lifetime maximum per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 36 consecutive months.
• Recall oral examination:	Once every 6 consecutive months.
• Specific oral examination:	2 exams per calendar year.
• Emergency oral examination:	2 exams per calendar year.
• Complete series of periapical films or panoramic radiographs:	Panoramic radiograph, once every 36 consecutive months. All others, unlimited.
• Polishing:	Once every 6 consecutive months.
• Bitewing radiographs:	Unlimited.
• Scaling:	10 units combined with root planing per calendar year for patients over the age of 13. One unit every six months for patients under the age of 13.

• Root planing:	10 units combined with root planing per calendar year for patients over the age of 13. One unit every six months for patients under the age of 13.
• Fluoride treatment:	Once every 6 consecutive months for children under the age of 16.
• Tooth coloured (composite) filling:	Eligible on all teeth.
• Veneers:	Once every 60 consecutive months.
• Special periodontal appliances, including occlusal guards and bruxism appliances:	One appliance every 60 months.
• Adjustments to periodontal appliance to control bruxism:	One visit every calendar year.
• Pit and fissure sealants:	Once every 36 consecutive months on molars and pre-molars.
• Occlusal equilibration:	8 units per calendar year.
• Space maintainers:	For children under the age of 16.
• Oral hygiene instruction:	Once per insured person per lifetime.
• Anaesthetic:	Reasonable and customary charges.
• Denture adjustments including minor adjustments:	Reasonable and customary charges.
• Denture rebase/reline:	Once every 36 consecutive months.
• Preformed stainless steel and polycarbonate crowns:	Reasonable and customary charges.
• Crowns, inlays & onlays:	Once every 60 consecutive months.
• Bridges & dentures:	Once every 60 consecutive months.
• Laboratory fees:	Limited to 50% of fees specified for the dental treatment or service.
Termination:	When you reach age 70 or retire, whichever comes first.

General Information

This Plan Supplements Provincial Plans

This group benefit plan is designed to supplement protection, not duplicate or take the place of, the benefits available under provincial hospital and medical care plans. Therefore, this benefit plan excludes care and services that can be provided under a provincial plan. The group plan cannot provide any benefits where care or treatment by private insurance is prohibited.

Who is Eligible

Active employees residing in Canada who are a permanent employee, are actively working at least 40 hours and week and have completed the waiting period.

Spousal and Dependant coverage is available subject to the terms and conditions of this booklet.

Waiting Period

Benefits are effective the first day following three months of continuous service.

When Coverage Begins

Active employees:

- When the eligibility and waiting period requirements have been satisfied.

Inactive employees:

- Upon return to active employee status.

Dependants:

- the date employee coverage begins (if a dependant has been identified); or,
- the date a dependant becomes eligible for coverage; or
- the dependant coverage application date, provided the application is made within 31 days of initial eligibility for dependant coverage otherwise;
- the date the plan administrator approves the evidence of insurability submitted for the dependant.

IMPORTANT: 31 days after the effective date of coverage, late applicants will be required to submit evidence of insurability for each dependant.

Complete a new Enrolment form to add or change a legally married or common-law spouse, or add or remove a child and submit to your human resources office or the plan administrator.

Definitions

Active employee or employee actively at work: an employee who performs all of the usual customary duties of the occupation.

Dependant child:

- an unmarried person who is a natural, adopted, or step child;
- a child of a common-law spouse, who resides with you and is dependent on you for support; and
  (i) younger than 21 years of age and not employed on a regular full-time basis; or
  (ii) 21 years or older in full-time attendance at an accredited institute of learning, and dependent on you for support; or

(iii) 21 years or older and incapable of self-sustaining employment due to a mental or physical handicap. The child's coverage will be continued under the policy, provided the child's handicap has existed continuously from a time when he/she was otherwise insured as a dependant under this policy. Supporting documentation by a physician will be required.

Dependant coverage is not available to children who work more than 30 hours per week and are not full-time students or who are not residents of Canada.

To avoid delays or processing problems, contact the plan administrator when any change in dependant status occurs.

Disability: defined under the life insurance and long-term disability (LTD) sections of this booklet.

Fees and 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.

Inactive / unemployed: an employee who is temporarily absent from work due to disability, temporary lay-off, authorized leave of absence.

Insured person: employee, spouse and dependant child with coverage.

Reasonable and customary: 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 essential to the diagnosis and management of the disease or injury.

Revocable / Irrevocable beneficiary: *Revocable beneficiary* is the person that you name to receive the benefits of an insurance policy can be changed. *Irrevocable beneficiary* is the person that you name to receive the benefits of an insurance policy that cannot be changed without the irrevocable beneficiary's written consent.

Spouse: can be:
- an individual to whom the employee is legally married; or
- a common-law partner, with whom you have co-habited for a period of at least 12 months and who is publicly presented as your spouse/partner.

Members must state the name of the person to be considered a spouse for the purposes of the policy. Only one spouse will be covered under the policy at any time and must be a resident of Canada.

Change in Information

To ensure you receive all correspondence and that the correct information is stored in your file, contact your employer or the plan administrator as soon as a change occurs (i.e. new dependant or beneficiary, address changes, change in marital status).

Coverage Following the Termination of Extended Health and Dental Care Benefits

If your extended health and/or dental care coverage terminates for 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 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

When payment for benefits provided under this plan is available to a person under any other pre-paid health service contract, insurance policy or plan, benefits shall be co-ordinated and the amount payable under this agreement shall be pro-rated and limited to the extent that the total amount available under all coverages does not exceed 100% of the eligible expenses.

The plan administrator may obtain from or release to any person or corporation, any information considered necessary to implement this provision and facilitate the payment of benefits under this plan, subject to consent of the covered member, if so required by law.

In co-ordination of benefits situations where Coughlin is secondary payer, the original Explanation of Benefits from the primary insurer and copies of the relevant receipts or dental claim form must be submitted.

Order of Benefits Determination

If you or your dependants are eligible to receive a benefit under this plan and the same or similar benefit under any other plan, benefit payment shall be decided in the following manner:

- if another plan does not contain a co-ordination of benefits provision, the benefits of that plan will be paid first prior to the application of benefits under this plan;
- if another plan contains a co-ordination of benefits provision, its benefits will be co-ordinated with the benefits under this plan as follows:

  Priority shall be attributed to the plan under which the person is eligible to receive the benefits in the following order:
  (i) the benefits payable under a plan which insures the individual other than as a dependant will be determined before the benefits of a plan which insures the individual as a dependant;
  (ii) the benefits payable under a plan that insures the individual as a dependant of a covered person with the earlier month and day of birth in the calendar year; or
  (iii) the benefits payable under a plan that insures the individual as a dependant 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:
  (i) the plan of the parent with custody of the child;
  (ii) the plan of the spouse-partner of the parent with custody of the child;
  (iii) the plan of the parent not having custody of the child; or
  (iv) 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:
  (i) the plan where the employee is an active, full-time employee;
  (ii) the plan where the employee is an active, part-time employee; or
  (iii) 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 you and/or your eligible dependants incur any eligible expenses for medically necessary services or supplies, the benefit plan will pay a benefit subject to limitations and exclusions. The benefit payable will be based on the amount shown in the Benefit Summary following the payment of the annual deductible, if applicable. All covered services and supplies must be considered reasonable and acceptable by the Canadian medical profession and proven to be effective and in a form, intensity, frequency and duration essential to the diagnosis and treatment of the illness or injury. Certain drugs may require prior authorization from the plan administrator.

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.

Covered Expenses

The plan will pay for the following services and supplies providing they are not covered by the provincial health care plan to the limits specified in the *Benefit Summary.*

Prescription Drugs and Medication

- Diabetic supplies such as diabetic needles, syringes, test strips and lancets.
- Certain eligible medications may require the prior authorization of the plan administrator.
- Compound mixtures, when at least one ingredient is a prescription requiring medication.
- Drugs, sera and injectables only available when prescribed by a physician or dentist.
- Charges for nicotine replacement products or smoking cessation therapies.
- Fertility drugs.
- Oral contraceptives.
- Drugs and supplies available without a prescription and required as a result of a colostomy or ileostomy and/or the treatment of cystic fibrosis, diabetes and Parkinson’s or heart disease.
- Sclerosing injections used in the treatment of varicosities, when his treatment is primarily for therapeutic and not cosmetic purposes, up to the maximum specified in the *Benefits Summary*.
- Viscosupplementation devices are eligible up to the plan limitation listed in the *Benefit Summary*.

Hospital Care

The plan will cover the costs for 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 or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

The plan will also cover accommodations in a convalescent hospital if this care has been ordered by a doctor, up to the maximum listed in the *Benefits Summary.*

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

If you enter a detoxification facility, the plan will pay expenses to the limits outlined in the Benefit Summary at the usual and customary charges applicable to provincially approved detoxification facilities, provided treatment is pre-approved by the plan administrator. The facility must specialize in the rehabilitation of alcohol and other substance abuse addictions, including all care and services related to the treatment provided the insured is receiving curative treatment and the facility is run by a licensed physician and is under the constant supervision of a registered nurse.

Palliative care establishment means any establishment in Canada designated as such by law that provides, under the supervision of a physician, care and treatment to patients, mainly during the terminal phase of their illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a physician. An active treatment hospital designated as such by law, extended care facility, rest home, convalescent or rehabilitation centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a palliative care establishment.

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.

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.

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 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.

- Elastic support stockings, including compression hose, showing the brand name and compression ratio.

- 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 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, in the province of residence in effect at the time of the treatment.

Out-of-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.
- 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 a doctor or dentist
    - treatments for weight loss, 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*
- In respect to these benefits, no payment will be made for expenses that are related to services, treatments or supplies payable by or covered by a government plan.

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 the 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 or will involve major dental services, 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
- 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
- Replacement a natural tooth or teeth extracted after the effective date of coverage and the appliance is installed after the person has been covered for a minimum of one year.

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.

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 habit

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 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.
- Services and supplies related to implants.
- Expenses incurred for correction of temporomandibular joint dysfunction (TMJ).
- 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 Claim

In the event of a death, your beneficiary should immediately contact your employer who will provide the necessary information.

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

Accidental Death and Dismemberment (AD&D) Insurance Claim

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

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

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred. Claim forms are available from your employer.

Long-Term Disability Insurance Claim

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

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

The carrier must receive notice of claim on the earlier of the following dates:

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

Part of the application process will include filling out claim forms that give as many details about the claim as possible. You, the attending doctor and your employer will be required to complete the claim forms. In order to receive benefits, the carrier must receive these forms no later than 90 days after the end of the elimination period.

The carrier will assess the claim and send you or your employer a letter outlining the decision.

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

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

In the event of a claim, immediately contact the 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;

Reimbursement Details Regarding 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 shall not be payable on any reimbursement under this plan. All expenses incurred and paid by the participants shall be deemed to have been incurred and paid in Canadian dollars and reimbursement shall be in Canadian dollars.

Reimbursement

Reimbursement shall 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 shall 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.

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 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 #59468
Certificate number – printed on your card

Dental:
BIN/Carrier ID #000034
Group Number #59468
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. ET

APPENDIX A –

Basic Member Life, Dependant Life, Optional Life, Spousal Optional Life, Short Term Disability and Long Term Disability Insurance

Underwritten by SUN LIFE ASSURANCE COMPANY OF CANADA

The benefit summary provides coverage highlights for these benefits.

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to these benefits.

Sun Life Financial

your group benefits

Ottawa Carleton Association for Persons with Developmental Disabilities

Open Hands Full-Time Employees

Contract Number 50948
Effective January 1, 2019

Table of Contents

General Information

About this booklet

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

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

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

Eligibility

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

- you are a permanent employee.
- you are actively working for your employer at least 40 hours a week.
- you have completed the waiting period.

The waiting period for your group plan is 3 months of continuous employment.

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

rehabilitation program.

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, is an eligible dependent. You can only cover one spouse at a time.

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

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

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

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

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

Enrolment

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

request dependent coverage.

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

When coverage begins

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

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

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

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

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

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

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

Changes affecting your coverage

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

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

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

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

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

When coverage ends

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

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

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

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

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

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

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

The continuation of coverage does not apply to the spouse's Optional Life.

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions

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 total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Medical examination

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

Recovering overpayments

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

Assignments

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

Definitions

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

Accident

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

Appropriate treatment

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

Basic earnings

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

Doctor

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

Illness

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

Retirement date

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

We, our and us

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

Short-Term Disability
(Weekly Indemnity)

General description of the coverage

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

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

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

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

When disability payments begin

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

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

In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized.

If you are totally disabled for part of any week, we will pay 1/7 of the weekly benefit for each day you are totally disabled.

If you become totally disabled during a lay-off or approved leave and

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

Interrupted periods of disability

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

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

What we will pay

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

Step 1: We take 66.67% of your weekly basic earnings up to a maximum of $800.

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

Step 2: We subtract any income provided to you:

- under a motor vehicle insurance plan which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.

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

After the first 17 weeks of total disability, when the maximum benefit period is more than 17 weeks, we also subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases that occur after benefits begin.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under any coverage resulting from your membership in an association of any kind.

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

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

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

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

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

Maternity / parental leave of absence

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

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

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

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

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

If you recover damages from another person

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

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

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

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

When payments end

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

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

When coverage ends

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

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence*. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.

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

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

We will not pay for total disability resulting from:

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

When and how to make a claim

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

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

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

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

Long-Term Disability

General description of the coverage

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

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

For your Long-Term Disability coverage,

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

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

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

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

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

Proof of good health

Proof of good health is required for coverage in excess of $4,000, and any increase in that coverage of 25% or more or $500, whichever is greater. Coverage will not take effect before Sun Life approves the proof of good health.

When disability payments begin

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

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

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

What we will pay

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

Step 1: We take 66.67% of your monthly basic earnings up to a maximum of $6,000.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers'

Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.

- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under the Québec Parental Insurance Plan.

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

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

Additional sources of income provided to you:

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

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

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

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

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

Maternity / parental leave of absence

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

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

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

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

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

Partial disability program

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

After you are eligible for Long-Term Disability payments, you may be

considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

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

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

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

Rehabilitation program

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

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

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

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

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

Interrupted periods of disability during elimination period

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

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

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

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

Interrupted periods of disability after payments begin

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

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

If you recover damages from another person

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

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

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

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

Your responsibilities

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

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

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

When payments end

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

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

When coverage ends

Long-Term Disability coverage will end on the day you reach age 65

less the elimination period of 17 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

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

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

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

- you became totally disabled more than 12 months after your coverage began.

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

We will not 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.

When and how to make a claim

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

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

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

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

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

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

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

Life Coverage

General description of the coverage

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

Basic Life coverage for you

Amount

Your Life benefit is 2 times your annual basic earnings, rounded to the next higher $1,000. The maximum amount of coverage is $250,000.

Reduction

Your benefit will reduce to 50% of the above amount when you reach age 65.

Coverage ends

Your coverage will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount

You can choose coverage in units of $10,000. The maximum amount of coverage is $200,000.

Coverage ends

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

Basic Life coverage for your dependents

Amount

Your spouse’s benefit is $5,000. Your children's benefit is $2,500 per child.

Coverage ends

Coverage for your dependents will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Amount You can choose Optional Life coverage for your spouse in units of $10,000 up to a maximum of $200,000.

Coverage ends Optional coverage for your spouse will end when you retire or reach age 65. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

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

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

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

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

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

Suicide

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, we

will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

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

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

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

Total disability must continue for:

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

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

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

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

totally disabled under the Life benefit.

Converting Life coverage

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

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

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

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

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

When and how to make a claim

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

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

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

This group plan arranged by:
Coughlin & Associates Ltd.
Tel. (613) 231-2266
Fax (613) 231-2345

APPENDIX B –

Out-of-Province/Canada Medical Emergency Insurance

Underwritten by AIG INSURANCE COMPANY OF CANADA

Contact **Coughlin & Associates Ltd.**, your benefits administrator for any and all questions related to this benefit.

EMERGENCY OUT OF PROVINCE MEDICAL

For all in benefit Members of

Ottawa-Carleton Association for Persons with Developmental Disabilities

OCAPDD / AOCPDI
Open Hands

POLICY NUMBER
CMG 9429097

September 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 in benefit Members under Ottawa-Carleton Association for Persons with Developmental Disabilities and their eligible dependents whose names are on file with the Policyholder and as shown below are insured under this Plan.

Class I: All eligible active unionized Employees under age 70.
Class II: All active Employees ages 70 to 75.
Class III: All eligible active non-unionized and Opens Hands Employees under age 70.
Class IV: All eligible retired Directors under age 75.

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 60 consecutive days.

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:

Under age 70 - $5,000,000.00 lifetime maximum
Ages 70 to 74 - $2,000,000.00 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 9429097.

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 9429097

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.

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 9429097

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