Your Group Insurance Plan

Executives

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COUGHLIN

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 booklet outlines the specific terms of your group benefit plan as well as the coverage levels of each benefit. Be sure to keep this booklet in a safe place for future reference.

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, Optional Life and Long-Term Disability (LTD) Insurance	Sun Life Assurance Company of Canada (Sun Life)	101719	Appendix A
Accidental Death & Dismemberment Insurance	AIG Insurance Company of Canada	BSC 9110550 PAI 9110551	Appendix B
Extended Health Care and Dental Care	Almonte General Hospital Administered by Coughlin & Associates Ltd.	26041	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 Almonte General Hospital 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.

Almonte General Hospital, 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 Almonte General Hospital.

As sponsor of the plan, the Almonte General Hospital 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 the Almonte General Hospital, 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:	Option 1: $5,000 Option 2: Two times your annual basic earnings rounded to the nearest $500.
Proof of good health:	Approval required to change coverage from Option 1 to Option 2.
Maximum amount:	$750,000.
Termination:	When you retire.

Paid-Up Life Insurance

Retirees

Benefit amount:	$300 for each completed year of service.
Maximum amount:	$4,500.
Termination:	Upon your death.

Employee Optional Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	You can choose coverage in units of $10,000, subject to approval of evidence of insurability.
Maximum amount:	$500,000.
Termination:	When you reach age 65, or retire, whichever occurs first.

Spouse Optional Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	You can choose coverage in units of $10,000, subject to approval of evidence of insurability.
Maximum amount:	$500,000.
Termination:	When you reach age 65 or retire, or when your spouse reaches age 65, whichever occurs first.

Basic Accidental Death and Dismemberment (AD&D) Insurance

REFER TO APPENDIX B – AIG INSURANCE COMPANY OF CANADA

Benefit amount:	Equal to your Basic Life Insurance.
Maximum amount:	$750,000.
Termination:	When you reach age 70, or retire, whichever occurs first.

Optional Accidental Death and Dismemberment (AD&D) Insurance

REFER TO APPENDIX B – AIG INSURANCE COMPANY OF CANADA

For Employees:

Benefit amount:	Available in units of $10,000.
Maximum amount:	$500,000.
Termination:	When you reach age 70, or retire, whichever occurs first.

For Dependants:

Benefit amount:	Spouse only: 60% of the employee's principle sum. Spouse with dependant children: 50% of the employee's principle sum. Each child: 15% of the employee's principle sum if the plan includes spousal coverage; 20% if there is no spousal coverage.
Termination:	When you reach age 70, or retire, whichever occurs first.

Long-Term Disability (LTD) Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	If you have less than 20 years of service: 65% of your monthly basic earnings, up to a maximum of $12,000. If you have at least 20 years, but less than 30 years of service: 70% of your monthly basic earnings, up to a maximum of $12,000. If you have at least 30 years of service: 75% of your monthly basic earnings, up to a maximum of $12,000.
Maximum benefit period:	If you have less than 10 years of continuous service when you become totally disabled: • period ending on the last day of the month in which you reach age 65 if the elimination period is completed on or before you reach age 64

	• the date you have received 12 months of Long-Term Disability payments if the elimination period is completed after you reach age 64 but before you reach age 65. If you have 10 years or more of continuous service when you become totally disabled – The date you die
Proof of good health:	Approval required for coverage in excess of $10,000 and any increase in that coverage of 25% or more, or $500, whichever is greater.
Elimination period:	30 weeks.
Tax status:	Taxable.
Termination:	When you reach age 65 (less the elimination period), or retire, whichever occurs first.

Extended Health Care Benefits

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum benefit:	Unlimited
Termination:	Active employees: When you reach age 70, or retire, whichever occurs first. Retirees: When you reach age 65.

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

Prescription drugs:

Deductible:	$22.50 per insured person, $35 per family per calendar year.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Eligible drugs:	Drugs, serums, vaccines and injectables, only available by prescription with a valid drug identification number (DIN), when prescribed by a licensed health care practitioner or dentist dispensed by a pharmacist, dentist or a physician.
Drug card:	Yes.
Maximums and exclusions:	
− Drugs:	Limited to a 3 month supply.
− Sclerosing injections for the treatment of varicosities:	Excluded.
− Viscosupplementation:	Excluded.
− Smoking cessation aids:	Unlimited.

– Sexual dysfunction drugs:	Excluded.
– Fertility treatment:	Excluded.

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

Hospital care:

Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Coverage:	Semi-private coverage: Supplemental hospital coverage must be selected at time of enrolment for semi-private coverage. Private coverage: The plan covers the difference between semi-private room rate and private room rate, provided semi-private hospital was not waived at enrolment. Private hospital: Lifetime maximum of $10 per day to a maximum 120 days.
Palliative care:	Covered under the hospital care coverage as indicated above.
Convalescent/chronic care:	Combined maximum of $3.00 per day to maximum 120 days every 12 consecutive months. Semi-private accommodation. Must commence withing 14 days following hospitalization of at least 5 days. Physician's referral required.

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

Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum:	$400 per insured person every 24 consecutive months. When prescribed, includes eyeglasses (including repairs), contact lenses, and laser eye surgery.
Laser eye surgery:	Eligible every 24 consecutive months on an ongoing basis to the benefit maximum or the insured person no longer qualifies.
Glasses or contact lenses following cataract surgery or Artificial crystalline lenses, also known as intraocular lenses (IOL) for cataracts:	Lifetime maximum of one per eye.
Eye examinations:	One exam per insured person for any period of 24 consecutive months performed by a registered optometrist or ophthalmologist.

Professional and paramedical services:

Reimbursement level:	100% of eligible expenses (unless otherwise specified).
• Maximum per practitioner:	
– Chiropractor:	$400 per insured person per calendar year, including X-rays.
– Massage therapist:	$400 per insured person per calendar year.
– Physiotherapist:	$400 per insured person per calendar year.
– Psychologist, or psychotherapist:	Combined maximum of $200 per insured person per calendar year. Limited to up to $35 for the first visit and up to $20 per hour thereafter.
– Speech therapist:	$200 per insured person 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):	Eligible.
– Surgical brassieres:	Reasonable and customary charges.
– Private duty nurse:	$25,000 per insured person each calendar year. Physician's referral required. Prior approval required.
– Artificial eye:	Eligible. Physician's referral required.
– Artificial appendage:	Eligible. Physician's referral required.
– Stump socks:	Excluded.
– Orthopaedic shoes:	Reasonable and customary charges.
– Custom made orthotics or arch support:	Reasonable and customary charges.
– Elastic support stockings:	Reasonable and customary charges. Physician's referral required.
– Conventional wheelchair:	Reasonable and customary charges.
– Other therapeutic equipment:	Reasonable and customary charges.
– Hearing aids:	Lifetime maximum of $500 per insured person, Includes cost of repairs and maintenance.
– Diagnostic services:	Reasonable and customary charges.
– Wigs as result of medical condition:	Lifetime maximum of $500 per insured person.
– Glucometer or reflectance meter, (includes Freestyle	Eligible.

	Libre flash monitoring system and associated sensors):	
–	TENS nerve stimulators:	Excluded.
–	Intra-uterine devices:	Excluded.
–	Out of province referral treatment:	Excluded.

Prior authorization of any anticipated expenses for medical supplies and services should be obtained from the plan administrator, Coughlin & Associates Ltd. Supporting documents should be submitted for review to ensure eligibility based on the plan parameters.

Contact Coughlin & Associates regarding required documentation for prior authorization.

Dental Care Benefit

Deductible:	Nil.
Fee guide:	Based on current year Ontario Dental Association fee guide for general practitioners.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
– Maximum:	Unlimited.
– Denture services:	50% of eligible expenses.
– Maximum:	$1,000 per insured person each calendar year.
• Major services:	100% of eligible expenses.
– Maximum:	$2,000 per insured person each calendar year.
• Orthodontic services:	50% of eligible expenses.
– Maximum:	Lifetime maximum of $2,000 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 9 consecutive months.
• Recall oral examination:	Once every 9 consecutive months.
• Specific oral examination:	Once every 9 consecutive months.
• Complete series of periapical films or panoramic radiographs:	Once every 36 consecutive months.
• Polishing:	Once every 9 consecutive months.
• Bitewing radiographs:	Unlimited.
• Scaling:	6 units per calendar year.
• Root planing:	Reasonable and customary charges.
• Fluoride treatment:	Unlimited.

• Tooth coloured (composite) filling:	Eligible on all teeth.
• Special periodontal appliances, including occlusal guards and bruxism appliances:	Reasonable and customary charges.
• Adjustments to periodontal appliance to control bruxism:	Eligible.
• Pit and fissure sealants:	Eligible.
• Occlusal equilibration:	8 units per 12 months.
• Space maintainers:	Eligible.
• Oral hygiene instruction:	Unlimited.
• Anaesthetic:	Eligible in relation to covered procedures.
• Denture adjustments including minor adjustments:	Eligible.
• Denture rebase/reline:	Eligible.
• Preformed stainless steel and polycarbonate crowns:	Eligible.
• Crowns, inlays & onlays:	Once every 5 years. Excludes porcelain crowns for molar teeth.
• Veneers:	Once every 5 years.
• Bridges & dentures:	Once every 5 years.
• Implants	Excluded.
• Laboratory fees:	Limited to 60% of the fees specified for the dental treatment or service.
• TMJ related services:	Excluded.
Termination:	Active employees: When you reach age 70, or retire, whichever occurs first. Retirees: When you reach age 65.

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 permanent employees residing in Canada who work a minimum of 24 hours per week. Six months of continuous service is required for the Long-Term Disability benefit. All other benefits require three months of continuous employment.

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

When Coverage Begins

Active employees:

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

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 stepchild;
- a child of a common-law spouse, who resides with you and is dependent on you for support; and
  - (i) under age 21 and not employed on a regular full-time basis; or
  - (ii) under age 25 and in full-time attendance at an accredited institute of learning, and dependent on you for support; or
  - (iii) of any age and is unable to support themselves due to a mental or physical disability. The child's coverage will be continued under the policy, provided the child's disability 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.

Comparable Coverage

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

Change in family status means:

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

Late Applicants

Applicants who apply for coverage after 31 days of the termination of comparable coverage will be required to provide evidence of insurability. In order to qualify for benefit coverage, you must meet certain medical standards, as set by the administrator, to rule out any significant financial risk to the plan sponsor. Coverage may be approved or declined based on the information provided.

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).

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, as specified in the *Benefits Summary*.
- the date you are no longer actively working.
- the date you die.
- the end of the period for which premiums have been paid for your coverage.
- the date the group contract or the benefit provision ends.

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

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

The end of coverage may vary from benefit to benefit. For information about a specific benefit, refer to the *Benefits Summary*.

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 *Benefits 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 *Benefits 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 licensed health care practitioner or dentist.
- Charges for nicotine replacement products or smoking cessation therapies, up to the maximum specified in the *Benefits Summary*.
- 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

Hospital Care

Supplemental Hospital Expense Benefit

This benefit pays the difference between standard ward and semi-private accommodation in public general hospitals.

Hospital Expenses Benefit

In Canada, this benefit pays the difference between the semi-private room rate and private room accommodation, provided semi-private hospital coverage was requested at enrolment.

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.

A chronic care hospital is a licensed hospital that provides chronic care for patients who are chronically ill, whose chronic care needs cannot be provided at home. The patient requires a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse. If the plan member is confined in a chronic hospital or chronic care unit of a public general hospital, reimbursement will be made up to the maximum indicated in the *Benefits Summary.*

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. It is strongly recommended that prior authorization, accompanied by supporting documents, be submitted prior to incurring expenses for medical equipment with substantial cost implications.

- Hearing aids, or repairs to existing hearing aids. 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.
- Wigs for patients who have undergone chemotherapy treatment or have a medical condition, to the limits outlined in the *Benefits Summary*;
- 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. 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), cryo-cuffs, cervical collars, standard-type artificial limb or eye. Braces must be constructed with rigid or semi-rigid material, required for normal activities of daily living, and not solely for sports-related activities, with the written prescription of a physician.

- Purchase of colostomy and ileostomy supplies (where surgical stoma exists), payable after incurred expenses exceed the provincial health plan.
- Laboratory tests performed by a commercial laboratory for the diagnosis of an illness.
- Medical services and supplies including bandages, surgical dressings, blood transfusions, plasma, radium and radioactive isotope treatments when authorized by the patient's attending physician.
- Certain diagnostic laboratory services and X-rays, except for those provided by a doctor in the course of treatment and not normally covered by the provincial health care plan.

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.
- Sclerosing injections used in the treatment of varicosities.
- Fertility drugs.
- Sexual dysfunction drugs.
- 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.
- Transcutaneous electric stimulators (TENS) machines.
- 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, including drugs, proteins and food or dietary supplements
  - hair growth stimulants
  - contact lens care products and eye lubricant
  - dietary supplement, diet foods, vitamins, vitamin supplements, minerals other than hematinics, and anorexiants
  - food and food products including infant formula, infant foods, salt and sugar substitutes
  - skin and hair care products, including protectives, soaps, cleansers, emollients, lubricants, suntan lotions and deodorants
  - personal hygiene products, contraceptive preparations and devices
  - dental and oral hygiene products, including toothpastes, mouthwashes, and prophylaxis treatments
  - lozenges and cough suppressants or antacids, anti-flatulents and absorbents
  - medications for pets
  - laxatives, anti-diarrheals and hemorrhoidals
  - drugs listed as excluded in the *Benefits Summary*
- 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

Prior Extraction Clause

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

Pontics

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

Retainers, crowns

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

Orthodontic Services

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

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

- Services for diagnostic purposes
- Preventive orthodontic treatment
- Comprehensive orthodontic treatment
- Appliances to control harmful oral habits

Expenses Not Covered

- Services, treatments or supplies, eligible under this plan and payable under any government plan, including any no-fault motor vehicle insurance plan.
- Expenses incurred 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.
- Expenses incurred for correction of temporomandibular joint dysfunction (TMJ).
- 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 or supplies relating to dental implants.
- Personal Protective Equipment (PPE).
- All fees charged by medical practitioners for the completion of medical forms or other documentation or charges incurred for failing to keep a scheduled appointment or for the transfer of medical files.
- Services or supplies purchased outside Canada except as provided under the out-of-country care provision.

How to Claim Benefits

Life Insurance Claims

In the event of a death, your beneficiary should immediately contact 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 which 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.

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

Reimbursement

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

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

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

Member Portal – Electronic Claims

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

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

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

Pre-Authorized Deposit (PAD)

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

To enrol in the PAD program:

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

Point-of-Service Claims Submission

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

Pharmacy :	**Dental:**
BIN/Carrier ID #34	BIN/Carrier ID #000034
Group Number # 59110	Group Number # 59110
Certificate number – printed on your card	Certificate number – printed on your card

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

Submitting Paper Claims

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

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

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

Dental Care Claims

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

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

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

Claims Appeals Process

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

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

Contact Us

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

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

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

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

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

APPENDIX A –

Basic Life, Optional Life and Long Term Disability Insurance

UNDERWRITTEN BY **SUN LIFE ASSURANCE COMPANY OF CANADA**

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

Contract Number: 101719
Effective: April 1, 2015
Issued: August 2, 2018

your group benefits

Almonte General Hospital

Executives

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How to Connect with Sun Life Financial and Coughlin & Associates Ltd.

Questions?

We're here to help. Talk to a Customer Care representative for assistance with your coverage, by calling:

- Sun Life toll free at 1-800-361-6212 for Life Coverage and Long-Term Disability.
- Coughlin & Associates Ltd. at 613-231-2266 for all other benefits.

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

Benefit Summary

Contract Number 101719

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

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Waiting Period	The waiting period is: • 6 months of continuous employment for Long-Term Disability • 3 months of continuous employment for all other benefits Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Long-Term Disability

Maximum amount	If you have less than 20 years of service – 65% of your monthly basic earnings, rounded to the next higher $1, up to a maximum of $12,000 If you have at least 20 years, but less than 30 years of service – 70% of your monthly basic earnings, rounded to the next higher $1, up to a maximum of $12,000 If you have at least 30 years of service – 75% of your monthly basic earnings, rounded to the next higher $1, up to a maximum of $12,000 The maximum amount may be reduced by benefits and payments provided from other sources as described in *the Long-Term Disability* section of this booklet
Proof of good health	Approval required for coverage in excess of $10,000, and any increase in that coverage of 25% or more or $500, whichever is greater
Elimination period	30 weeks

Maximum benefit period	If you have less than 10 years of continuous service when you become totally disabled: • period ending on the last day of the month in which you reach age 65 if the elimination period is completed on or before you reach age 64 • the date you have received 12 months of Long-Term Disability payments if the elimination period is completed after you reach age 64 but before you reach age 65 If you have 10 years or more of continuous service when you become totally disabled – The date you die Benefits may also end on an earlier date as specified in the Long-Term Disability section of this booklet
Termination	The day you reach age 65 less the elimination period or the day you retire, whichever is earlier
Tax status	Your employer has indicated that it is paying all or a portion of the premium for this disability plan. Therefore, the benefit payments are taxable income.

Life

Employee Basic Life

Amount	Option 1 – $5,000 Option 2 – 2 times your annual basic earnings rounded to the nearest $500 Maximum – $750,000
Proof of good health	Approval required if you request to increase your coverage from Option 1 to Option 2
Reduction	When you retire or reach age 65, whichever is earlier, your benefit will reduce to an amount of Paid-Up Life insurance equal to $300 for each completed year of service Maximum – $4,500

Employee Optional Life

Amount	You can choose coverage in units of $10,000 Maximum – $500,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 65, whichever is earlier

Spouse Optional Life

Amount	You can choose coverage in units of $10,000 Maximum – $500,000

Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier

Making Claims

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

To assess a claim, Sun Life or Coughlin & Associates Ltd. may ask you to send them the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information Sun Life or Coughlin & Associates Ltd. needs.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

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

Type of claim	Starting the claims process	Limits and special instructions
Long-Term Disability	To make a claim, complete the claim forms available from your employer. Ensure that the following people complete them: • you • your attending doctor • your employer. The submission of these forms is your proof of claim.	You should submit your proof of claim at least 8 weeks prior to the completion of your elimination period, but in no event later than 90 days after the end of your 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 continued total disability. We must be provided with this information within 90 days of the request.
Life coverage	Ask your employer to provide the claim forms.	We must receive the claim form as soon as possible after the death occurred. **For Coverage during total disability:** We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

General Information

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

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

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

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

Who is eligible to receive benefits?	To be eligible for group benefits, you must live in Canada and meet all the following conditions: • you are a permanent employee working in Canada. • you are actively working for your employer at least 24 hours a week. • you have completed the waiting period indicated in the Benefit Summary. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent You must apply for coverage for yourself in order for your dependents to be eligible.
Who qualifies as your dependent	Your dependent must be: • your spouse, and • living in Canada. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage • under any other formal union recognized by law • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship You can only cover one spouse at a time.
How to enrol	*For you* – You must provide the proper enrolment information to Coughlin & Associates Ltd. through your employer. *For a dependent* – You must ask for dependent coverage. If your enrolment request is not received within 31 days of becoming eligible to receive it – You will have to provide proof of good health at your own expense. You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health. • Employee Basic Life • Employee Optional Life • Spouse Optional Life • Long-Term Disability

When coverage begins	Your coverage begins **on the later of** the following dates: • the date you become eligible for coverage. • the date you enrol for coverage. • the date Sun Life approves your proof of good health, if required. If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work. A dependent’s coverage begins **on the later of** the following dates: • the date your coverage begins. • the date the dependent becomes eligible for coverage. • the date Sun Life approves the dependent’s proof of good health, if required. 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.
Changes affecting your coverage	If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health. If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer: • change of dependents. • change of name. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-800-361-6212.
When coverage ends	As an employee, your coverage will end on the earlier of the following dates: • the date your employment ends for any reason other than retirement on pension. • the date you are no longer actively working. • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends. A dependent’s coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage.

	The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

Legal actions

Limitation period for Ontario:

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

Limitation period for any other province:

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

Proof of disability

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

Medical examination

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

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:
- ask you to reimburse us.
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

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

Definitions

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

Accident	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
Appropriate treatment	Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.
Basic earnings	Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.

	If you are a commissioned salesperson, if you have been employed for at least one calendar year, basic earnings are the earnings reported on your previous year's T4 income tax slip. If you have been employed less than one calendar year, basic earnings are your estimated annual earnings based on your actual earnings since your date of hire.
Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Illness	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Long-Term Disability

General description of the coverage

Long-Term Disability coverage provides a benefit 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 it started.

For the purposes of your Long-Term Disability coverage:

- during the first 2 years (this period is known as the **regular occupation period**), we consider you to be totally disabled while you are in a state of complete and continuous incapacity resulting from illness that wholly prevents you from performing each and every function of your regular occupation.
- afterwards, we will consider you to be totally disabled while you are continuously unable due to an illness to perform any occupation, for any employer, for which you are qualified by education, training or experience.

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

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

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

When disability payments begin	Your Long-Term Disability payments begin **on the later** of the following dates: • after you have been totally disabled for the uninterrupted period indicated in the Benefit Summary. • after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan. This period, which must be completed before disability benefits become payable is called the **elimination period.**
What we will pay	Here is how we calculate your Long-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions. **Step 1: We take the maximum amount indicated in the Benefit Summary.** **Step 2: We subtract any benefits or payments provided under:** • any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan, excluding any benefits or payments on behalf of a dependent, for the same or a subsequent disability. • any Workers' Compensation Act or similar law for the same or a subsequent disability. • a motor vehicle insurance plan. • a group plan, including any coverage you have because you are a member of an association but excluding any benefits or payments provided under a Critical Illness plan. • if you have less than 10 years of continuous service when you become totally disabled – a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition, but excluding any shortened life expectancy benefits.** • if you have 10 years or more of continuous service when you become totally

disabled – a retirement or pension plan funded in whole or in part by your employer, but excluding any shortened life expectancy benefits.**
- the Québec Parental Insurance Plan.

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

Take the result you got in Step 2, add the above sources of benefits and payments plus the other sources of benefits and payments listed below and check the total you get. If it's more than 85% of your basic earnings when your disability began, we will reduce your Long-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

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

For employees under age 65, your Long-Term Disability payment will never be less than $50.

Important to remember:
- **If you choose to apply for, and are approved for, the HOOPP disability pension benefit, you will receive a disability pension benefit (immediate, unreduced pension based on your contributory service) upon termination of your employment with the hospital. If you choose to take free accrual (you continue to build contributory service under the plan while off work due to disability) there will be no change to your monthly Long Term Disability payments. If you decide to take the disability pension benefit, we will subtract the amount of disability pension you are receiving from your monthly Long Term Disability payments.
- If you are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Long-Term Disability payments. This does not apply to the HOOPP Disability pension benefit. If you choose not to apply for the HOOPP Disability pension benefit, you will not be penalized and no estimated offset will be applied to your payments.
- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Long-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again (reoccurs) due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 180 days of the end of your previous disability.

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

Rehabilitation / Partial disability program

Sun Life may require you to participate in a partial disability or rehabilitation program that we have approved in writing. A rehabilitation program must also be approved by the treating doctor.

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

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

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

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

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

If you recover damages from another person

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

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

For disability benefits paid or payable prior to the date of trial or settlement, if you recover money, you must pay us 75% of your net recovery or the total disability benefits paid or payable to you under this plan, whichever is less. For disability benefits payable after a settlement or trial, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits. Refer to your group contract for more information.

What you are responsible to do

During your total disability, you must make reasonable efforts to do all of the following. If you do not, Sun Life may hold back or discontinue benefits.
- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your regular occupation during the first 2 years of total disability.
- receive training to qualify for another occupation if it becomes apparent that you will not be able to return to your regular occupation within the first 2 years of total disability.
- try to get work in another occupation after the first 2 years of total disability.
- obtain benefits that may be available from other sources.

When payments end

If you have less than 10 years of continuous service when you become totally disabled, your Long-Term Disability payments end **on the earlier of** the following dates:
- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the 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.

If you have 10 years or more of continuous service when you become totally disabled, your Long-Term Disability payments end **on the earlier of** the following dates:
- the date you are no longer totally disabled.
- the date you die.

When coverage ends

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

What is not covered

We will not pay benefits for any period during which:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except if 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.
- you are absent from Canada longer than 4 months due to any reason.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay benefits for total disability resulting from:

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

Waiver of premium

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

Life Coverage

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.

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

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

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

Living Benefits Loan Program

If you are terminally ill with a life expectancy of 24 months or less, you may apply for a commercial loan under the Sun Life Living Benefits Loan Program. Under this program, you may receive an advance of up to 50% of your Basic Life coverage, to a maximum of $100,000.

If you are within 5 years of a scheduled reduction of your Basic Life coverage, the advance you may receive cannot exceed 50% of the lowest reduced amount of your Basic Life coverage, to a maximum of $100,000. If you are within 5 years of the termination of your Basic Life coverage, you may not apply for a commercial loan under the Sun Life Living Benefits Loan Program. This program is subject to other restrictions. Please contact your employer for details.

Converting Life coverage

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

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

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

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).

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than one in six Canadians, in over 12,000 corporate, association, affinity and creditor groups across Canada.

Our Core values – integrity, service excellence, customer focus and building value – are at the heart of who we are and how we do business.

Sun Life Financial and its partners have operations in 22 key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

GB10171-E

APPENDIX B –

Accidental Death & Dismemberment Insurance

UNDERWRITTEN BY **AIG Insurance Company of Canada**

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

Basic and Voluntary Accidental Death & Dismemberment
West Ottawa Valley Network
Policy No.: BSC 9110550
Policy No.: PAI 9110551

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences, even for a two income family. A serious injury may prevent you and your loved ones from meeting your financial obligations. And your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer has provided for you Accident Insurance coverage. And your employer is also offering you through the benefit of group buying power, the opportunity to purchase simple and affordable Personal Accident Insurance coverage. Both coverages are underwritten by AIG Insurance Company of Canada. Each policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident or if you or your eligible insured dependants should suffer loss of life, or 'living benefits' should a covered accident result in paralysis or loss of use of a limb, sight, speech or hearing.

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

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

How It Works

Under the Basic Accident Insurance BSC 9110550

You are automatically covered if you are eligible for coverage under your Group Life Insurance Policy and who is under the termination age of the Basic Life benefit. You are insured for an amount equal to your Group Life Insurance Policy to a maximum of $750,000.

Under the Voluntary Accidental Insurance PAI

You choose a Principal sum amount for yourself and your eligible Dependents, which is set out on your application to enroll. You are eligible to enroll if you belong to one of the following classes:

Class I: All active, permanent full-time employees of the Policyholder, under age 70, who subscribe to an optional individual or family plan.

Class II: All active, permanent part-time employees of the Policyholder, under age 70, who subscribe to an optional individual or family plan.

Only those that request optional coverage would be covered.

For a Principal amount of:

Class I: a minimum of $ 10,000 and a maximum of $ 500,000 in units of $ 10,000

Class II: a minimum of $ 10,000 and a maximum of $ 500,000 in units of $10,000

If the insured Employee enrolls for Family coverage and the Insured has:

(a) **Employee** - From $10,000 - $500,000 in $10,000 increments.

(b) **Spouse -** Spouse will be insured for 50% of the Employee's Principal Sum if dependent children, or 60% if no dependent children.

(c) **Children -** Each dependent child will be insured for 15% of the Employee's Principal Sum if spouse, and 20% if no spouse.

Definitions

"Insured Employee" means you, if you are a permanent, active full-time or part-time employee of the Policyholder who is under the termination age of the Basic Life benefit.

Eligible Dependents:

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

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

Beneficiary Designation under the Basic Accident Insurance BSC 9110550

Indemnity payable in the event of the Loss of Life of an Insured Employee will be payable to the beneficiary designated by the Insured Employee on his enrollment card on file with the Policyholder's Basic Group Life Insurance policy, or, if there is no such beneficiary designation, such indemnity will be payable to the estate of the Insured Employee.

All other indemnities payable, will be payable to the Insured Employee.

Beneficiary Designation under the Voluntary Accidental Insurance PAI 9110551

The employee accidental death benefit will be paid to the designated beneficiary or the estate if no such designation is made. All other indemnities payable (including benefits payable for losses sustained by covered dependents) will be paid to the Insured Employee.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

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

Table of Losses

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

Loss of Use

Loss of use of both arms or both hands .... The Principal Sum
Loss of use of one hand or one foot... Two-thirds of the Principal Sum
Loss of use of one arm or one leg .... Three-quarters of the Principal Sum

Paralysis

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

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid. "Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $10,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $10,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $1,000 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $10,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 200 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $10,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 200 kilometres from home.

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

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

Day Care Benefit
Pays an annual benefit of up to 3% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

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

Spousal Educational Benefit
Pays a benefit of up to $10,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

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

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

Common Disaster Benefit (under the Voluntary Accidental Death and Dismemberment Only)
If you and your Insured Spouse both are injured in the same accident and both die within 90 days of the accident as a direct result of such injuries, your Spouse's Principal Sum amount will be increased to equal yours.

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

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

Extended Family Coverage
If you die, the coverage of your insured Spouse and/or insured Dependent Children will continue for up to 6 months, subject to payment of premium.

Conversion Privilege Benefit

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

Policy Exclusions

The policy does not cover any loss, fatal or non-fatal, caused by or resulting from:

1. Suicide or any attempt thereat by the Insured Person while sane or self destruction or any attempt thereat by the Insured Person while insane.
2. Injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in Part B of Section II, Definition of Injury and Scope of Coverage.
3. Declared or undeclared war or any act thereof.
4. Active full time service in the armed forces of any country.

Aggregate Limit Per Accident

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

Effective Date under the Basic Accident Insurance BSC 9110550

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

Effective Date under the Voluntary Accidental Insurance PAI 9110551

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

Termination Date

Coverage ends on the earliest of:

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

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