Queensway Carleton Hospital

Your Group Insurance Plan

Executives of the QCH Foundation

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COUGHLIN
employee benefits specialists

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, Long-Term Disability (LTD) and Out-of-province/Canada Medical Emergency Insurance	Sun Life Assurance Company of Canada (Sun Life)	102019	Appendix A
Optional Critical Illness Insurance	Sun Life Assurance Company of Canada (Sun Life)	105600	Appendix B
Accidental Death & Dismemberment Insurance	AIG Insurance Company of Canada	BSC 9110550 BSC 9110551	Appendix C
Extended Health Care and Dental Care	Queensway Carleton Hospital Administered by Coughlin & Associates Ltd.	26011	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 Queensway Carleton 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.

Queensway Carleton 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 Queensway Carleton Hospital.

As sponsor of the plan, Queensway Carleton 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 Queensway Carleton 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:	Four times your annual basic earnings rounded to the next higher $1,000.
Maximum amount:	$500,000.
Reduction:	50% reduction at age 65.
Termination:	When you reach age 70, or retire, whichever occurs first.

Employee Optional Life Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Benefit amount:	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 70, 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 70 or retire, or when your spouse reaches age 70, whichever occurs first.

Basic Accidental Death and Dismemberment (AD&D) Insurance

REFER TO APPENDIX C – AIG INSURANCE COMPANY OF CANADA

Benefit amount:	Equal to your Basic Life Insurance.
Maximum amount:	$500,000.
Termination:	When you reach age 80, or retire, whichever occurs first.

Optional Accidental Death and Dismemberment (AD&D) Insurance

REFER TO APPENDIX C – 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:	75% of your monthly earnings, up to a maximum of $10,000.
Maximum benefit period:	The last day of the month you reach age 65.
Elimination period:	30 weeks.
Tax status:	Taxable.
Termination:	When you reach age 65 (less the elimination period), or retire, whichever occurs first.

Out-of-Province/Canada Medical Emergency Insurance

REFER TO APPENDIX A – SUN LIFE ASSURANCE COMPANY OF CANADA

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses.
Maximum amount:	Lifetime maximum of $3,000,000 per insured person.
Coverage period:	90 days per trip.
Termination:	Active employees: When you reach age 80, or retire, whichever occurs first.

Employee Optional Critical Illness Insurance

REFER TO APPENDIX B – SUN LIFE ASSURANCE COMPANY OF CANADA

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

Early retirees and part-time employees are not covered under this benefit.

Spouse Optional Critical Illness Insurance

REFER TO APPENDIX B – SUN LIFE ASSURANCE COMPANY OF CANADA

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

Early retirees and part-time employees are not covered under this benefit.

Extended Health Care Benefits

Deductible:	Nil.
Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum benefit:	To age 65: Unlimited

	Over age 65: Lifetime maximum of $15,000 for expenses incurred in Canada, excluding medical and surgical incurred out of province but in Canada in the case of emergency expenses.
Termination:	Active employees: When you reach age 80, or retire, whichever occurs first. Early retirees: Age 65.
Note: Some individual benefits are subject to monthly, yearly or lifetime maximums.	

Prescription drugs:

Deductible:	$10 per insured person, $20 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 100-day supply.
– Sclerosing injections for the treatment of varicosities:	Maximum $20 per visit (cost of medication only).
– Viscosupplementation:	Excluded.
– Smoking cessation aids:	Lifetime maximum of $550 per insured person, including patches and chewing gum when prescribed.
– 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 or private accommodations.
Palliative care:	Covered under the hospital care coverage as indicated above.
Convalescent/chronic care:	Combined maximum of 100 days per hospitalization period. Must commence less than 14 days following a period of hospitalization. Physician's referral required.

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

Reimbursement level:	100% of eligible expenses (unless otherwise specified).
Maximum:	$450 per insured person every 24 consecutive months. When prescribed, includes eyeglasses, 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.
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:	
– Chiropodist:	$400, maximum one visit per day, per insured person per calendar year. Includes one x-ray per calendar year.
– Chiropractor:	$450, maximum one visit per day, per insured person per calendar year. Includes one x-ray per calendar year.
– Massage therapist:	$450, maximum one visit per day, per insured person per calendar year.
– Naturopath:	$200, maximum one visit per day, per insured person per calendar year.
– Occupational therapist:	$400, maximum one visit per day, per insured person per calendar year.
– Osteopath	$400, maximum one visit per day, per insured person per calendar year.
– Physiotherapist:	$450, maximum one visit per day, per insured person per calendar year.
– Podiatrist	$400, maximum one visit per day, per insured person per calendar year.
– Psychologist, psychotherapist, or social worker:	Combined maximum of $800, maximum one visit per day, per insured person per calendar year.
– Speech therapist:	$400, maximum one visit per day, 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) or surgical brassieres:	Combined maximum of $200 per insured person per calendar year.
– 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:	Reasonable and customary charges.
– Orthopaedic shoes:	$300 per insured person every 2 calendar years when prescribed by a Podiatrist, Chiropodist or Physician.
– Custom made orthotics or arch support:	$300 per insured person every 2 calendar years when prescribed by a Podiatrist, Chiropodist or Physician.
– Elastic support stockings:	4 pairs per insured person each calendar year. Physician's referral required.
– Conventional wheelchair:	Reasonable and customary charges.
– Other therapeutic equipment:	Reasonable and customary charges.
– Hearing aids and related devices:	Lifetime maximum of $700 per insured person. Includes related services; excludes replacement batteries.
– Diagnostic services:	Reasonable and customary charges.
– Wigs as result of medical condition:	Lifetime maximum of $300 per insured person.
– Glucometer or reflectance meter, (includes Freestyle Libre flash monitoring system and associated sensors):	Eligible.
– TENS nerve stimulators:	Lifetime maximum of $300 per insured person.
– Intra-uterine devices:	Eligible.
– Out of province referral treatment:	Lifetime maximum of $50,000 per insured person. Expenses must be submitted to the provincial plan first. Early retirees are not eligible.

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 Dental Association fee guide for general practitioners where service is rendered.
Reimbursement amount:	
• Basic services:	100% of eligible expenses.
– Maximum:	Unlimited.
• Major services:	50% of eligible expenses.
– Maximum:	Unlimited.
• Orthodontic services:	50% of eligible expenses.
– Maximum:	Lifetime maximum of $2,000 per insured person.
Treatment frequency:	
• Complete oral examination:	Once every 6 consecutive months.
• Recall oral examination:	Once every 6 consecutive months.
• Specific oral examination:	Once every 6 consecutive months.
• Complete series of periapical films or panoramic radiographs:	Once every 24 consecutive months.
• Polishing:	Once every 6 consecutive months.
• Bitewing radiographs:	Unlimited.
• Scaling:	12 units combined with root planing per calendar year.
• Root planing:	12 units combined with scaling per calendar year.
• 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:	Eligible.
• Space maintainers:	For missing primary teeth only for children under age 18.
• Oral hygiene instruction:	Unlimited.
• Anaesthetic:	Eligible in relation to dental surgery.
• 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	Alternate Benefit Clause will be applied.
• 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 80, or retire, whichever occurs first. Early retirees: 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 20 hours per week. The waiting period is three months of continuous service for all benefits.

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 22 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.
- Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to the maximum specified in the *Benefits Summary*.
- 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

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*;
- Transcutaneous electric stimulators (TENS) machines, to the maximums specified 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.
- The costs of treatment for the repair or replacement of natural teeth, which require treatment as a result of accidental blow to the mouth. Damage must be caused by a direct blow to the mouth, not from an object wittingly or unwittingly placed in the mouth. The accident must have occurred after the effective date of the plan. Treatment must begin within 12 months of the date of the accident. Reimbursement will be based on the current Dental Association fee guide for general practitioners where treatment is rendered.

Out-of-Canada Referral Treatment

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

1) This service or treatment must not be available in Canada or in the normal province of residence of the insured person;
2) The insured person must provide the insurer with a letter of referral from a physician in his normal province of residence, indicating that he is being referred to another physician;
3) The insurer must give prior written approval;
4) The provincial health and/or hospital insurance plans must pay a portion of the eligible expenses.

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

Expenses Not Covered

- Services covered by any provincial government plan or any workers' compensation board.
- Any care, services or supplies that are not medically necessary, as determined by the plan administrator.
- Services or supplies to the extent that their costs exceed the reasonable and customary rates in the locality where the services or supplies are provided.
- Care, services or supplies utilized as treatment of lifestyle choices, as determined by the plan administrator.
- Services or supplies that are primarily for cosmetic purposes.
- Drugs or medicines, services or supplies that have been self-prescribed, or prescribed by or for family members.
- Drugs, injectables, supplies or appliances that are experimental or that are not approved by Health Canada.
- Charges for nicotine replacement products or smoking cessation therapies.
- 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.
- 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.

Dental Implants

Dental implants and related services are covered up to the maximum listed in the *Benefits Summary*.

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.
- 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.

Critical Illness Insurance Claim

In the event of a critical illness claim, immediately contact the carrier who will provide the necessary information and forms. Initial contact with the insurer must be within 30 days after the date of diagnosis or surgery.

Proof of claim should be submitted up to 90 days after the date of diagnosis or surgery.

Failure to contact the insurer or furnish proof of claim within the above time limits does not invalidate the claim if the contact is made or the proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to contact us or furnish proof within the above time limits.

Out-of-Province/Canada Medical Emergency Insurance Claim

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

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

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

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

Reimbursement Details Regarding Extended Health Care and Dental Care Claims

To be eligible for reimbursement, Coughlin & Associates Ltd. must receive proof of claim within 24 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 # 59090	Group Number # 59090
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.

Coughlin & Associates Ltd.'s Preferred Provider Network (PPN)

To avoid dispensing fees above the Ontario Drug Benefit (ODB) program maximum, use Coughlin & Associates Ltd.’s Preferred Provider Network of pharmacies throughout Ontario.

Participating pharmacies guarantee to limit their dispensing fee to the current ODB program maximum. They also agree to reduce their mark-up on certain drugs.

To find the PPN pharmacy nearest you, visit www.coughlin.ca and enter your postal code in the Preferred Provider Network (PPN) pharmacy locator tool.

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 Employee Life, Optional Life, Long Term Disability and Out-of-Province/Canada Medical Emergency 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.

Published: April 4, 2024
Q1,Q2,Q3 WOVNQC Foundation Execs 042024

COUGHLIN
employee benefits specialists

your group benefits

Contract Number: 102019
Effective: October 1, 2023
Issued: October 11, 2023

Queensway Carleton Hospital

Full-Time and QCH Foundation Executives

Sun Life Financial

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How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Customer Care representative for assistance with your coverage, by calling toll-free at 1-800-361-6212.

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

Your Travel Card

Provided by your employer.

Note: If you have refused Out-of-province Extended Health Care coverage under this plan, this travel card does not apply to you.

Need to contact Sun Life's Emergency Travel Assistance provider?

In the USA and Canada, call: 1-800-511-4610.

All other inquiries

Call 1-877-SUN-LIFE (1-877-786-5433).

Benefit Summary

Contract Number **102019**

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	3 months of continuous employment 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.

Out-of-province Extended Health Care

Benefit year	January 1 to December 31
Deductible	None
Reimbursement level	
Out-of-province emergency services	100% Emergency Travel Assistance included Maximum of 90 days per trip Lifetime maximum of $3,000,000 per person for out-of-province services
Out-of-province referred services	100% Lifetime maximum of $50,000 per person for out-of-province services
Termination	When you retire or reach age 70, whichever is earlier

Long-Term Disability *only for Classes 9 and 9A*

Maximum amount	75% of your monthly basic earnings, rounded to the next higher $1, up to a maximum of $10,000 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
Elimination period	30 weeks

Maximum benefit period	The period ending on the last day of the month in which you reach age 65 Benefits may also end on an earlier date as specified in the *Long-Term Disability* section of 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	4 times your annual basic earnings rounded to the next higher $1,000 Maximum – $500,000
Reduction	Coverage is reduced to 50% of the above amount when you reach age 65
Termination	When you retire or reach age 70, whichever is earlier

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 70, 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 70, or when your spouse reaches age 70, 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 may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information Sun Life 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
Out-of-province Extended Health Care	Ask your employer for the form to complete.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which you incur the expenses, or • 90 days after the end of your Out-of-province Extended Health Care coverage.
Emergency Travel Assistance	Contact Sun Life's Emergency Travel Assistance provider to notify them that a medical emergency exists.	**Having your expenses reimbursed:** To have Sun Life reimburse you for services or supplies you have paid for, you must provide proof of the expenses to us within 30 days of returning to the province where you live. Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.

Type of claim	Starting the claims process	Limits and special instructions
Long-Term Disability ***only for Classes 9 and 9A***	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	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.

Classes	This booklet describes the coverage for the following classes of employees: • Class 9 – Full-Time Executives • Class 9A – QCH Foundation Executives (Active) under 65 • Class 9A – QCH Foundation Executives (Active) over 65
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 20 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 or your child, and • living in Canada. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage • under any other formal union recognized by law • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least the last 12 months. There is no minimum cohabitation period if a child is born out of the relationship. You can only cover one spouse at a time. **Your children and your spouse's children** (other than foster children) are eligible dependents if they are under age 22 and do not have a spouse. A child who is a full-time student until age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse.

	If a child becomes disabled before the maximum age and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**
How to enrol	*For you* – You must provide the proper enrolment information to Sun Life through your employer. *For a dependent* – You must ask for dependent coverage. If you or your dependents already have similar Out-of-province Extended Health Care coverage under this or another plan – You may refuse this coverage under this plan. If the other coverage ends at a later date, you can enrol for coverage under this plan then. 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 Optional Life • Spouse Optional Life
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. This restriction does not apply to increases in coverage requested during a maternity / paternity leave of absence.
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 or you retire. • the date you are no longer actively working. • the date you die. • 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.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total eligible expenses.

However, when you have more than one plan, industry standards decide which plan you should claim expenses from first.

Please send in claims for you and your spouse in the following order:

- First, send in the claim to the plan where the person is covered as an employee. If the person is an employee under two plans, send the claim to your different plans in the following order:
  - to the plan where the person is covered as an active full-time employee.
  - then, to the plan where they are covered as an active part-time employee.
  - then, to the plan where they are covered as a retiree.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

- First send the claim in to the plan where the child is covered as an employee.
- Then, to the plan where they are covered under a student health or dental plan through their educational institution.
- Then, to the plan of whichever parent has the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.

When you send us a claim, you must tell Sun Life about all other equivalent coverage that you or your dependents have.

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.
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.
Medical specialist	A medical specialist is a licensed medical practitioner who has been trained in the specific area of medicine, and who has been certified by a speciality examining board.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Out-of-province Extended Health Care

General description of the coverage

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

Out-of-province Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed.

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required for treating an illness according to Canadian medical standards.

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

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

Reference to Doctor may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a doctor.

Claiming when the expense is incurred	You must claim any expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. 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.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

Expenses out of your province

Expenses out of your province	We will cover emergency services while you are outside the province where you live. We will also cover referred services. **For both emergency services and referred services, the reimbursement level is indicated in the Benefit Summary.**

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

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

Emergency services

We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established treatment program that existed before they left their home province.

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

Contact us right away in an emergency!
You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away. Sun Life's ETA provider must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them.

If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.

In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards.

An emergency ends when Sun Life's ETA provider, based on available medical evidence, deems you medically stable to return to the province where you live.

Emergency services excluded from coverage

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

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

Referred services	*Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services. All referred services must be obtained in Canada, if available, regardless of any waiting lists. However, if referred services are not available in Canada, they may be obtained outside of Canada.

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 for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integrating this plan with government programs

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

The covered expense under your employer's plan is the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

Emergency Travel Assistance

General description of the coverage

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

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Out-of-province Extended Health Care coverage. We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

The emergency services excluded from coverage, and all other conditions including maximums, limitations and exclusions that apply to your Out-of-province Extended Health Care coverage also apply to Medi-Passport.

Bring your Travel card with you! There you will find telephone numbers and the information you'll need to confirm your coverage and get help.

Getting help	**Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away.
	If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card. Sun Life's ETA provider may arrange for:
On the spot medical assistance	Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities. As soon as Sun Life's ETA provider is notified that you have a medical emergency, its staff, or a physician designated by Sun Life's ETA provider, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Sun Life's ETA provider will also guarantee or advance payment of the expenses incurred to the provider of the medical service. Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel. Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility	Sun Life's ETA provider may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation. Sun Life or Sun Life's ETA provider, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.
Meals and accommodations expenses	If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Sun Life's ETA provider will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days. Sun Life's ETA provider will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Sun Life's ETA provider, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.
Travel expenses home if stranded	Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live: • for you if, due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated (sent home); or • **for a child** if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified person to go home with the child as their attendant. We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.
Travel expenses of family members	Sun Life's ETA provider will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.
Returning you home (repatriation)	If you die while out of the province where you live, Sun Life's ETA provider will pay up to $5,000 to do the following: • arrange for all necessary government authorizations • arrange for the return of your remains in an approved container.

Returning your vehicle	Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 to return a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from doing so.
Lost luggage or documents	If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Sun Life's ETA provider will direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
Limits on advances	Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.
Reimbursement of expenses	If, after obtaining confirmation from Sun Life's ETA provider that you are covered and a medical emergency exists, Sun Life will reimburse you for services and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Sun Life's ETA provider. Sun Life's ETA provider's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-800-361-6212. Sun Life's ETA provider will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Sun Life's ETA provider before your claim can be processed.
Coordination of coverage	If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.
Your responsibility for advances	You will have to reimburse Sun Life for any of the following amounts advanced by Sun Life's ETA provider: • any amounts which are or will be reimbursed to you by your provincial medicare plan. • that portion of any amount which exceeds the maximum amount of your coverage under this plan. • amounts paid for services or supplies not covered by this plan. • amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you. Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received.
Limits on Emergency Travel Assistance coverage	There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before you leave on your trip.

	Sun Life's ETA provider reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: • rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or an act of God. • refusal of authorities in the country to permit Sun Life's ETA provider to fully provide service to the best of its ability during any such occurrence.
Liability of Sun Life or Sun Life's ETA provider	Neither Sun Life nor Sun Life's ETA provider will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Long-Term Disability for Classes 9 and 9A only

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 elimination period and the following 24 months (this period is known as the **own occupation period**), we consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own 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 or may become reasonably 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. • 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.
- any 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.

Important to remember:

- 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 6 months of the end of your previous disability.

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

Rehabilitation / Partial disability program

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

This may include one or more of the following:

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

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

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

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

Your participation in a partial disability program will be limited to the own 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 own occupation during the first 24 months that benefits are payable.
- receive training to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to get work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

When payments end

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

- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

Survivor benefit

If you die while you are receiving Long-Term Disability payments, we will pay 3 times your last monthly payment to your spouse, dependent children or your estate.

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 do not pay benefits if you become totally disabled within 12 months after your coverage begins and your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if you have been covered for Long-Term Disability with your employer for at least 13 weeks during which:

- you have been actively working continuously (up to 3 days of absence does not count), and
- you have not been treated for the condition by a doctor or any medical personnel under the direction of a doctor.

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

We will not pay benefits for total disability resulting from:

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

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

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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).

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

Sun Life Financial

APPENDIX B –

Optional Critical Illness 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.

Published: April 4, 2024
Q1,Q2,Q3 WOVNQC Foundation Execs 042024

CONTRACT HOLDER	Queensway Carleton Hospital
CONTRACT NUMBER	105600
CONTRACT EFFECTIVE DATE	January 1, 2012
CONTRACT ANNIVERSARIES	January 1, 2013 and the same day of each subsequent year
RENEWAL RATE EFFECTIVE DATES	January 1, 2013 and the same day of each subsequent year
PREMIUM DUE DATES	The effective date and the same day of each following month

This contract is issued by Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies, on the basis of the application of the contract holder and in consideration of the payment of premiums.

The terms printed on this and the following pages form part of the contract.

This amendment is accepted by the contract holder and the amended pages form part of the contract.

Amendment no. 1 effective February 1, 2015

The attached contract replaces the previous contract in its entirety.

Chief Executive Officer

Secretary

Benefit Details

Class A – All employees

Coverage	Employees are covered for: Critical Illness – Employee Optional and Spouse Optional
Eligibility requirements	An employee must: ■ be a permanent employee, and ■ be scheduled to work at least 20 hours a week.

CRITICAL ILLNESS

Employee Optional Critical Illness

Amount	As elected by the employee, units of $25,000 Maximum – $200,000 Required on all optional amounts of coverage, except for the first $50,000, depending on the amount elected, if the request is made during the enrolment period. Changes in coverage cannot be made after the enrolment period
Termination	When the employee retires or reaches age 65, whichever is earlier

Spouse Optional Critical Illness

Amount	As elected by the employee, units of $25,000 Maximum – $200,000
Proof of good health	Required on all optional amounts of coverage, except for the first $50,000, depending on the amount elected, if the request is made during the enrolment period. Changes in coverage cannot be made after the enrolment period
Termination	When the employee retires or reaches age 65, or when the spouse reaches age 65, whichever is earlier

1. Definitions

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.

Actively working

An employee is actively working if the employee is performing all the usual and customary duties of the employee's job with the employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if the employee was actively working on the last scheduled working day.

An employee is not considered to be actively working when receiving disability benefits.

Dependent

A dependent is a spouse who is a resident of Canada.

Employee

An employee is a person who is employed by the employer, is a resident of Canada and is working in Canada.

Employer

The employer is the contract holder.

Enrolment period

The enrolment period is from October 15, 2011 to December 15, 2011.

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.

Previous group contract

A previous group contract is a contract issued to the contract holder or employer by another insurance company or by Sun Life which provided benefits comparable to this contract, and which terminated and was replaced by this contract less than 31 days later.

Spouse

The employee's spouse by marriage or under any other formal union recognized by law, or a person of the opposite sex or of the same sex who is publicly represented as the employee's spouse.

Only one person at a time can be covered as an employee's spouse under this contract.

2. General Conditions of the Coverage

Eligibility for coverage

An employee is eligible for coverage under this contract if the employee:

- is a member of a class of employees defined in *Benefit Details* on the effective date of this contract,
- has elected coverage during the enrolment period, and
- meets all other eligibility requirements as outlined in *Benefit Details*.

A dependent becomes eligible for coverage on the date the employee becomes eligible. The employee must have elected dependent coverage during the enrolment period.

The employee must apply for employee coverage in order for the employee's dependents to be eligible.

Enrolment

To receive coverage, an employee must request coverage in writing by supplying the appropriate enrolment information to Sun Life through the employer. For a dependent to receive coverage, the employee must request dependent coverage.

When coverage begins

An employee's coverage begins on the later of the following dates:

- the effective date of this contract.
- the date Sun Life approves the employee's proof of good health, if required.

If an employee is not actively working on the date coverage would normally begin, then coverage will not begin until the employee returns to active work with the employer.

Dependent coverage begins on the later of the following dates:

- the effective date of this contract.
- the date Sun Life approves the dependent's proof of good health, if required.

If the dependent is hospitalized, dependent coverage will not begin before the dependent is discharged and resumes normal activities.

If an employee is not actively working on the date dependent coverage would normally begin, then that coverage will not begin until the employee returns to active work with the employer

Proof of good health

Sun Life requires proof of good health as specified in the *Benefit Details.*

When coverage ends

An employee's coverage ends on the earlier of the following dates:

- the date employment ends.
- the date the employee is no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for the employee's coverage.
- the date this contract ends, as specified under *Termination of the contract or a benefit provision*.

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

- the date the employee coverage ends.
- the date the dependent ceases to be an eligible dependent.
- the end of the period for which premiums have been paid for the dependent's coverage.

However, any benefit may end on an earlier date as specified in *Benefit Details*.

Continuation of coverage

When coverage would terminate because employment ends or the employee is no longer actively working, the employer is entitled to continue coverage in the following circumstances:

- during a statutory leave, as set out in applicable employment standards legislation, but not more than the period required under such legislation.
- during the notice period for termination of employment as required by relevant legislation.
- for a pre-determined period during which the employee is temporarily laid off or is granted a leave of absence, excluding a statutory leave or an absence due to illness, but not more than 3 months.

Also, when coverage would terminate because the employee is no longer actively working due to illness, the employer is entitled to continue coverage under this contract during the period the employee is absent from work, provided that employment continues.

The employer’s decision must be applied equally to all employees within the same classification as outlined in *Benefit Details*.

3. Critical Illness

Description of coverage

Critical Illness coverage provides a benefit in the amount specified in the Benefit Details if, after the effective date of coverage, and while coverage is in force, a person (an employee or the employee's spouse) has a diagnosis of a covered condition, or the person has surgery for a covered condition, as indicated below under *What Sun Life will pay*.

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

What Sun Life will pay

Sun Life will pay the Critical Illness benefit if, after the effective date of coverage, and while coverage is in force, a covered person has a diagnosis of a covered condition, or the person has surgery for a covered condition, subject to the survival period. Claims will be assessed based on the Critical Illness provisions in effect on the date of diagnosis or surgery.

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

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

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

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

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

Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a speciality examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

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

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

Proof of claim

Sun Life must receive notice of claim as soon as reasonably possible after the date of diagnosis or surgery. Sun Life will provide the claimant with the appropriate claim forms on receipt of notice. Initial notice must be received no later than 30 days and proof of claim no later than 90 days from the date of diagnosis or surgery.

Failure to give notice of claim or furnish proof of claim within the above time limits does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to give notice or furnish proof within the above time limits.

Who Sun Life will pay

The Critical Illness benefit is payable to the employee if living, otherwise to the employee's estate.

Changes in coverage

Changes in the covered conditions may occur as the result of a change in plan design.

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

- employees who are actively working;
- spouses who are not hospitalized; and
- employees and spouses already having Critical Illness coverage

on the date that the change occurs. The effective date of coverage for the new covered conditions is the date of the change to the plan.

For employees who are not actively working when the change occurs, the change will take effect when the employee returns to active work and such date will be the employee's effective date of coverage for the new covered conditions. For spouses who are hospitalized when the change occurs, the change will take effect when the spouse is discharged and resumes normal activities and such date will be the spouse’s effective date of coverage for the new covered conditions.

In all instances, Sun Life will:

- apply the effective date of coverage to determine the person's eligibility for a Critical Illness benefit payment; and

- apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where proof of good health was previously required for the person's coverage.

If the definition of a Critical Illness condition is changed, Sun Life will adjudicate any claim for a Critical Illness benefit based on the definition of that Critical Illness condition in effect on the date of the diagnosis or surgery, regardless of whether the employee was actively working or the spouse was hospitalized on the date of the change.

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

- the new plan, including coverage for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all employees and spouses on the effective date of this plan, regardless of whether the employee is actively working or the spouse is hospitalized on such date;

- for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of coverage is the effective date of this plan; and

- for Critical Illness conditions under this plan which were also covered under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of coverage is the date the person most recently became covered under the previous carrier's plan.

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

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

Covered conditions

Sun Life provides coverage for any illness, disorder or surgery that is defined below:

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

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

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

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

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

Bacterial Meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

Exclusion:

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

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

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

Exclusions:

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

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

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

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

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

Exclusions:

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

No benefit will be payable under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

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

Exclusion:

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

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

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

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

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

The covered person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Exclusion:

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

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

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

- heart attack symptoms;

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

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

Exclusions:

No benefit will be payable under this condition for:

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

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

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

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

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

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

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- Dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- Toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;

- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

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

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

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

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

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

Exclusion:

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

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

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

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

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

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

Motor Neuron Disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

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

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

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

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

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

- the date the employer receives enrolment information for such amount of coverage; or
- the effective date of such amount of coverage.

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

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

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

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

Exclusions:

No benefit will be payable under this condition if:

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

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

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

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

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

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

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

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

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

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

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

persisting for more than 30 days following the date of diagnosis.

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

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

Exclusions:

No benefit will be payable under this condition for:

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

What is not covered

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

No benefits are payable for claims resulting directly or indirectly from any of the following:

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

Pre-existing conditions – For any amount of coverage that:

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

no benefits are payable for any covered condition that results from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person, during the 12 months prior to the effective date of such amount of coverage:

- had signs, symptoms, consulted a physician or other health care practitioner; or
- was provided any health-related care, advice or treatment; or
- would have consulted a physician or other health care practitioner, acting as a reasonably prudent person with such injury, sickness, medical condition, signs or symptoms.

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

When coverage ends

Coverage ends on the date specified in *Benefit Details*. In addition, coverage may end on an earlier date, as specified in *General Conditions of the Coverage*.

Coverage for any person will also end on the date a Critical Illness benefit is paid for a covered condition which that person sustains.

Portability

If an employee's Critical Illness coverage ends for any reason other than the request of the employee, the employee may apply, without proof of good health, to transfer the group Critical Illness coverage to another critical illness policy, subject to the provisions described in *Critical Illness Coverage Portability.*

If a spouse's Critical Illness coverage ends for any reason other than the request of the employee, the spouse may apply, without proof of good health, to transfer the group Critical Illness coverage to another critical illness policy, subject to the provisions described in *Critical Illness Coverage Portability*.

Best Doctors

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

If the employee or the employee's spouse is covered for Critical Illness, the employee and the employee's spouse and children have access to Best Doctors.

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition, even if it is not a covered condition under this Critical Illness benefit.

Liability and responsibility of Sun Life for Best Doctors services

If a person obtains services, including the services of a physician or other health care professional, in connection with a referral by Best Doctors or any other Best Doctors service, the person who provides the services will not be considered to be acting on behalf of Sun Life, but rather on behalf of the person receiving the services.

Sun Life will not assume any liability or responsibility for:

- any services provided by Best Doctors.
- the negligence or other wrongful acts or omissions of any person, including a physician or other health care professional, providing services in connection with a referral by Best Doctors or any other Best Doctors service.

Best Doctors is not an agent, representative or service provider of Sun Life. No person will have any recourse against Sun Life for any damages or costs relating to or arising from Best Doctors services.

Sun Life cannot guarantee the availability of Best Doctors services.

Termination of Best Doctors services

Sun Life can terminate access to Best Doctors services by giving 15 days notice to the contract holder.

7. Claiming Benefits

Proof of claim

Sun Life must receive written proof of claim within the time limits shown under each benefit.

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

From time to time Sun Life may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the employee may not be entitled to some or all benefit payments.

The employee is responsible for all costs associated with any proof of claim.

Proof of age

Sun Life may require that any covered person provide proof of age. Sun Life may refuse to pay benefits until the proof is given.

If an incorrect age is given, Sun Life can adjust benefits and premiums based on the true age.

Paying benefits

Benefits payable during the lifetime of an employee are payable to the employee.

If the person, to whom a benefit is payable is not able to give a valid discharge, Sun Life may pay up to $10,000 to any person Sun Life considers appropriate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.

Legal actions

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

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

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim.

APPENDIX C –

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.

Published: April 4, 2024
Q1,Q2,Q3 WOVNQC Foundation Execs 042024

Group Personal Accident & Voluntary Accidental Death & Dismemberment Booklet

The policy and this booklet contain a provision removing or restricting the right of the insured and the group person insured to designate persons to whom or for whose benefit insurance money is to be payable.

Why You Should Have Accident Insurance

A serious accidental Injury or death can have tremendous consequences for your family that may prevent you or your Spouse from meeting your financial obligations. Your Employer has provided you with accident insurance coverage underwritten by AIG Insurance Company of Canada and is offering you the opportunity to purchase additional insurance coverage for you and your dependents. The policy provides a lump sum benefit to help ease any financial burden if you or your eligible insured dependents suffer a Loss of Life as a result of an accident. The policy also provides 'living benefits' should you or your eligible insured dependents suffer an accident that results in any of the Losses listed in the Table of Losses, such as Paralysis or Loss of Hearing.

Coverage is provided regardless of your health history. Your coverage is in force around-the-clock - at work, at home or at play, anywhere in the world.

Eligibility and Principal Sum

Group Personal Accident (GPA)
Your plan provides Accidental Death & Dismemberment benefits for Injuries as a result of covered accidents. You are automatically covered for a Principal Sum amount equal to that payable under your Basic Group Life Insurance Policy, to a maximum benefit amount of $750,000.

Group Voluntary Accidental Insurance (VOL)
You're eligible to enroll if you are a permanent, active full-time employee of Queensway Carleton Hospital. To include your dependent family members for coverage, select the family plan option.

You select the amount of coverage amount you need for yourself from a minimum of $10,000 up to a maximum of $500,000 in coverage, not to exceed 10 times salary.

If you elect family coverage the Principal Sum for your family is as follows:

(a) If you have a Spouse and Dependent Children, your Spouse's Principal Sum is 50% of your Principal Sum and each Dependent Child's Principal Sum is 15% of your Principal Sum; or
(b) If you have a Spouse only with no Dependent Children, your Spouse's Principal sum is 60% of your Principal Sum; or
(c) If you have Dependent Children only with no spouse, each Dependent Child's Principal sum is 20% of your Principal Sum.

For your convenience, if you elect this coverage, insurance premiums are automatically deducted from your payroll.

To learn more about this valuable benefit offering or if you're ready to enroll, contact your Human Resources Department today.

Definitions

The following is an explanation of commonly used terms in this benefit booklet. For the full list of definitions refer to the policy.

Annual Earnings means your annual salary from employment with your Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

Company means AIG Insurance Company of Canada.

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).

Employer means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

Hospital means an establishment which:

(a) holds a licence as a hospital (if licencing is required in the jurisdiction);

(b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(c) provides 24 hour a day nursing service by registered or graduate nurses;

(d) has a staff of one or more licenced Physicians available at all times;

(e) provides organized facilities for diagnosis, and major medical surgical facilities;

(f) is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and

(g) is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate Family means a person who is related to you or your eligible insured dependents in any of the following ways: a spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

Injury or ***Injuries*** means bodily injury which is sustained by you or your eligible insured dependents as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while your insurance under this policy is in force.

Insured Employee means an individual who belongs to an eligible class of Insured Employees specified in the Policy Schedule Declarations provided such individual's name is on file with the Policyholder as being insured under this policy.

Insured Person means an Insured Employees and, if the Insured Employee has selected family coverage, Insured Person also includes the Insured Employee's Spouse and Dependent Children (if any), also referred as eligible insured dependents.

Loss when used with reference to:

(a) ***Quadriplegia***, ***Paraplegia***, and ***Hemiplegia*** means the complete and irreversible paralysis of such limbs;

(b) ***Hand or Foot*** means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

(c) ***Arm or Leg*** means the complete severance through or above the elbow or knee joint;

(d) ***Thumb and Index Finger*** means the complete severance through or above the first phalange;

(e) ***Fingers*** means the complete severance through or above the first phalange of all four Fingers of one Hand;

(f) ***Toes*** means the complete severance of both phalanges of all the toes of one foot;

(g) ***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;

(h) ***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;

(i) ***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;

(j) ***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;

(k) ***Speech*** means complete and irrecoverable loss of the ability to utter intelligible sounds; and

(l) ***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.***

Physician means a medical doctor, other than you or your Immediate Family, who is licenced to administer medical treatment and prescribe drugs in the place where he or she provides medical services. The following are not considered to be Physicians: naturopath, herbalist and homeopath.

Private Passenger Type Automobile means any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

Spouse means a person 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, and is publicly represented as your domestic partner in the community in which you reside.

General Policy Provisions

Effective Date

Your coverage for Group Personal Accident begins on the date you satisfy the eligibility requirements to become an Insured Employee.

Your coverage for Voluntary Accidental Death & Dismemberment for yourself, Spouse or Dependent Child begins on the latest of: (1) the policy effective date; (2) the first day of the month following the 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 such person no longer satisfies the definition of an Insured Employee, Spouse or Dependent Child; or
4. the first day of the month following the date the Insured Employee no longer belong to an Eligible Class of Insured Employees as set out in the policy schedule.

Continuance of Coverage

If you are no longer employed or actively working, your coverage shall continue in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law, provided premiums continue to be paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage to an individual insurance policy that provides comparable coverage. The amount of insurance benefit provided for the new policy shall not exceed the lesser of $500,000 or your Principal Sum in force at the time you convert your policy. The premium due will be based on the rates in force for individual policies at time of application.

Benefits and Coverages

These benefits only include your eligible insured dependents if are paying for voluntary accidental death & dismemberment coverage.

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you or your eligible dependents sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

Table of Losses	Percentage Principal Sum Payable
Loss	
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	33.3%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	33.3%
Loss of All Toes of One Foot	25%
Loss of Use	
Loss of Use of Both Arms or Both Hands	100%
Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%
Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum up to a maximum of $1 million
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum up to a maximum of $1 million

Additional Benefits

These benefits shall only apply if selected by your Employer and the appropriate premium paid. The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

Benefit	Maximum	Benefit Description
DISAPPEARANCE	Principal Sum	Pays the Loss of Life Principal Sum if the body of you or your eligible insured dependents has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you or your eligible insured dependents were an occupant.
COMMON DISASTER BENEFIT – VOLUNTARY ONLY	Principal Sum	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.
REHABILITATION BENEFIT (INSURED EMPLOYEE ONLY)	$15,000	Pays the expenses incurred for your occupational training up to the Maximum if such expenses are incurred within three years of the accident and are as a result of an Injury for which you receive a benefit under the policy.
HOME ALTERATION AND VEHICLE MODIFICATION	$15,000	Pays a one-time benefit up to the Maximum for covered home alternation and vehicle modification expenses if you or your eligible insured dependents suffer an Injury for which you receive a benefit under the policy and require a wheelchair to be ambulatory.
WORKPLACE MODIFICATION AND ACCOMMODATION (INSURED EMPLOYEE ONLY)	$5,000	Pays a one-time benefit to your Employer up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require special adaptive equipment or workplace modification in order for you to return to work full-time for the Policyholder.
PSYCHOLOGICAL THERAPY	$5,000	Pays a benefit up to the Maximum if you or your eligible insured dependents suffer an Injury for which you receive a benefit under the policy and require psychological therapy within two years of the Injury.
IN-HOSPTIAL BENEFIT	$2,500/month	Pays a benefit of (i) 1% of the Principal Sum up to the Maximum for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than five but less than 30 nights, if you or your eligible insured dependents suffer an Injury for which you or your eligible insured dependents receive a benefit under the policy and are confined to hospital as a result of such Injury, for a maximum of twelve months.
FAMILY TRANSPORATION	$15,000	Pays a benefit up to the Maximum for the expenses incurred for the transportation of an Immediate Family member to your hospital if you or your eligible insured dependents suffer an Injury for which you receive a benefit under the policy and as a result are confined to a hospital more than 100 kilometres from home.
REPATRIATION BENEFIT	$15,000	Pays a benefit up to the Maximum to cover the expenses to return the body to your city of residence if you or your eligible insured dependents suffer a covered accidental death while at least 50 kilometres from home.
IDENTIFICATION BENEFIT	$5,000	Pays a benefit up to the Maximum for the transportation and commercial lodging of an Immediate Family member to identify the body if you or your eligible insured dependents suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.
DAY CARE BENEFIT	$5,000/year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the day care costs of each Dependent Child under age

Benefit	Maximum	Benefit Description
		13 who is enrolled, or who enrolls within 90 days, in a day care facility if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.
DEPENDENT CHILD EDUCATIONAL BENEFIT	$5,000/school year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the tuition costs of each Dependent Child who is enrolled as a full-time student in post-secondary education if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.
SPOUSAL EDUCATIONAL BENEFIT (INSURED EMPLOYEE ONLY)	$15,000	Pays a benefit up to the Maximum for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.
FUNERAL EXPENSE	$5,000	Pays a benefit up to the Maximum to reimburse funeral expenses if you or your eligible insured dependents suffer a covered accidental death.
BEREAVEMENT BENEFIT	$1,000	Pays up to the Maximum if you or your eligible insured dependents suffer loss of life in a covered accident and you or your eligible dependents require counselling within one year of the loss of life.
SEAT BELT AND AIR BAG BENEFIT	$50,000	Pays an additional benefit of 10% of the Principal Sum up to the Maximum if you or your eligible insured dependents suffer a covered accidental death while operating or riding as a passenger in a Private Passenger Type Automobile in which the seatbelt was properly fastened. If the seat belt benefit is payable and you or your eligible insured dependents were in a seat protected by a properly functioning supplemental restraint system which inflated on impact, an additional benefit of 10% of the Principal Sum will be paid. The Seat Belt and Air Bag Benefit is payable up to the Maximum combined.

Policy Exclusions

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

(a) suicide or any attempt thereat by you or your insured eligible dependents;

(b) self inflicted Injury or any attempt thereat by you or your insured eligible dependents;

(c) declared or undeclared war or any act thereof;

(d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

(e) Injury sustained while you or your insured eligible dependents are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

(f) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

(g) travel or flight in or on (including getting in or out of, or on or off of) any aircraft, if you or your insured eligible dependents are:

  (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

  (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

  (iii) riding as a passenger in an aircraft owned, leased or chartered by the Policyholder;

(h) travel or flight in or on (including getting in or out of, or on or off of) any aircraft or craft designed to fly or glide above the Earth's surface:

  (i) except as a passenger on a regularly scheduled commercial airline; or

  (ii) being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or

  (iii) operating to or from off-shore landing sites; or

  (iv) used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(j) Injury or Loss sustained if you or your insured eligible dependents are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;

(k) Injury or Loss sustained while you or your insured eligible dependents are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

(l) Injury or Loss sustained while you you or your insured eligible dependents are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;

(m) the commission or attempted commission by you or your insured eligible dependents or Injury incurred while you or your insured eligible dependentsare in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

(n) an act, attempted act or omission taken or made by you or your insured eligible dependents, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

(o) natural causes.

Claims Process

Beneficiary Designation

You have the option to designate a beneficiary. Should you choose not to, in the event of accidental Loss of Life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's basic group life policy. If there is no written designation validly made for the purposes of the Employer's current basic group life insurance policy then the benefit will be paid to your estate.

The amount payable for the loss of life of your eligible insured dependents is payable to you.

All other benefits will be payable to you.

How to Make a Claim

In the event of claim, claim forms can be obtained from your Employer.

Written notice of claim to the Company must be given no later than 30 days from the date of accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Benefit Cost for Voluntary Accidental Death & Dismemberment

The monthly cost for shown Principal Sums is as follows:

PRINCIPAL SUM	MONTHLY COST Employee Only	MONTHLY COST Employee and Family
$ 10,000.00	$0.19	$0.29
$ 20,000.00	$0.38	$0.58
$ 30,000.00	$0.57	$0.87
$ 40,000.00	$0.76	$1.16
$ 50,000.00	$0.95	$1.45
$100,000.00	$1.90	$2.90
$150,000.00	$2.85	$4.35
$200,000.00	$3.80	$5.80
$250,000.00	$4.75	$7.25

Important Notes

This booklet, as may be amended, provides only a summary of the provisions for the Group Personal Accident and Voluntary Accidental Death & Dismemberment coverage and the Additional Benefits. The full coverage details are contained in the

policy including eligibility, limitations, exclusions and termination provisions. In the event of a discrepancy between this booklet and policy, the terms of the policy shall govern.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. Possession of this booklet alone does not mean that you or your dependents are covered. The policy must be in effect and you must satisfy all the requirements.

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 (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), The Limitations Act (for actions or proceedings governed by the laws of Saskatchewan) or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Insurance is underwritten by AIG Insurance Company of Canada.