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FLEXIBLE GROUP BENEFITS PLAN

Booklet - Salaried Employees

CAESELECT

Contract number: 25289 Health/Dental Care/Health Spending Account
Contract number: 56289 Life Insurance/LTD/Critical Illness
Contract number: 150289 Personal Spending Account

CAE

Sun Life Financial

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Benefit Details

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or administrator.

In this section, you will find the options which are available to you under each benefit. For more information on each benefit, please refer to the appropriate section in this booklet.

Your Extended Health Care options

	Basic	Option 1	Option 2
Deductible	For prescription drugs: Employee and dependent children – $950 combined per benefit year Spouse – $950 per benefit year For other expenses – none	For prescription drugs – $7 for each prescription or refill For other expenses – none	For prescription drugs – $7 for each prescription or refill For other expenses – none
		The prescription drug deductible ceases to be applied for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached.	
Overall benefit year maximum	Not applicable	$800 per person	$1,600 per person
Overall lifetime maximum	Out-of-Canada emergency services –maximum of $3,000,000 per person All other expenses – none		
Prescription drugs *(The overall benefit year maximum only applies to intrauterine devices (IUDs), diaphragms, contraceptive patches and contraceptive delivery systems)*	For intrauterine devices (IUDs), diaphragms, contraceptive patches and contraceptive delivery systems – Not covered For vaccines – 100%, up to a maximum of $250 per person per benefit year For all other eligible expenses – 100%	For vaccines – 85%, up to a maximum of $350 per person per benefit year For all other eligible expenses – 85%	For vaccines – 100%, up to a maximum of $500 per person per benefit year For all other eligible expenses – 100%

	The reimbursement percentage is increased to 100% for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached. However, if the drug submitted for reimbursement has a lower priced equivalent drug, only the cost of the lowest priced equivalent drug will be considered at 100%, unless Sun Life specifically approved the cost of the higher priced drug		
Drug substitution limit	Charges in excess of the lowest priced equivalent drug are not covered.		
	For drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless Sun Life specifically approved the charges for the higher priced drug.		
Québec drug insurance plan	Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet the requirements		
Hospital expenses in your province *(The overall benefit year maximum does not apply to these services)*	100% semi-private room	100% semi-private room	100% semi-private room
Convalescent hospital	100% semi-private room	100% semi-private room	100% semi-private room
Chronic care (Long term)	100% semi-private room up to a maximum of $25 per day per person.	100% semi-private room up to a maximum of $25 per day per person.	100% semi-private room up to a maximum of $25 per day per person.
Nursing home	100% $25 per day per person.	100% $25 per day per person.	100% $25 per day per person.
Expenses out of your province *(The overall benefit year maximum does not apply to these services)*	Emergency – 100% Referral – 90%	Emergency – 100% Referral – 90%	Emergency – 100% Referral – 90%
Medi-Passport	Covered	Covered	Covered
Medical services and equipment			
Private duty nursing Max. per benefit year	100% $25,000 per person	100% $25,000 per person These expenses are not subject to the overall benefit year maximum	100% $25,000 per person These expenses are not subject to the overall benefit year maximum

Diagnostic services	100% (only employees are covered for these services)	Pregnancy related ultrasounds – 85% subject to the overall benefit year maximum Non-pregnancy related ultrasounds – 100% These expenses are not subject to the overall benefit year maximum All other diagnostic services: • Employee – 100% These expenses are not subject to the overall benefit year maximum • Dependents – 85% subject to the overall benefit year maximum	Pregnancy related ultrasounds – 100% subject to the overall benefit year maximum Non-pregnancy related ultrasounds – 100% These expenses are not subject to the overall benefit year maximum All other diagnostic services: • Employee – 100% These expenses are not subject to the overall benefit year maximum • Dependents – 100% subject to the overall benefit year maximum
Wheelchair cushion	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Rental, purchase or repair of a hospital bed	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Mechanical or hydraulic lifts	Not covered	85% up to a maximum of 1 lift and $2,000 per person over 5 benefit years These expenses are subject to the overall benefit year maximum	100% up to a maximum of 1 lift and $2,000 per person over 5 benefit years These expenses are subject to the overall benefit year maximum
Therapeutic mattress	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Rental, purchase or repair of wheelchairs and scooters	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum

Elastic support stockings	Not covered	85% up to a maximum of 2 pairs per person in a benefit year These expenses are subject to the overall benefit year maximum	100% up to a maximum of 2 pairs per person in a benefit year These expenses are subject to the overall benefit year maximum
Custom-made orthotic inserts, orthopaedic shoes and modifications to orthopaedic shoes	Not covered	85% up to a combined maximum of $300 per person per benefit year These expenses are subject to the overall benefit year maximum	100% up to a combined maximum of $300 per person per benefit year These expenses are subject to the overall benefit year maximum
Hearing aids	Not covered	85% up to a maximum of 1 per person over 5 benefit years subject to the overall benefit year maximum	100% up to a maximum of 1 per person over 5 benefit years subject to the overall benefit year maximum
Insulin pumps	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Living aids	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
All other covered medical services and equipment	100**%**	100% These expenses are not subject to the overall benefit year maximum	100% These expenses are not subject to the overall benefit year maximum
Paramedical services			
Speech therapists	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum

Psychologists, social workers or psychotherapists	100% up to a maximum of $750 per person per benefit year (only employees are covered for these services)	Employee – 100%, up to a maximum of $750 per benefit year. Once this maximum has been reached, additional expenses are reimbursed at 85%, subject to the overall benefit year maximum. Dependents – 85% subject to the overall benefit year maximum	Employee – 100%, up to a maximum of $750 per benefit year. Once this maximum has been reached, additional expenses are subject to the overall benefit year maximum. Dependents – 100% subject to the overall benefit year maximum
Physiotherapists	100% up to a maximum of $750 per person per benefit year (only employees are covered for these services)	Employee – 100%, up to a maximum of $750 per benefit year. Once this maximum has been reached, additional expenses are reimbursed at 85%, subject to the overall benefit year maximum. Dependents – 85% subject to the overall benefit year maximum	Employee – 100%, up to a maximum of $750 per benefit year. Once this maximum has been reached, additional expenses are subject to the overall benefit year maximum. Dependents – 100% subject to the overall benefit year maximum
Acupuncturists	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Massage therapists ***Services must be ordered by a doctor***	Not covered	85%, up to a maximum of $50 per visit These expenses are subject to the overall benefit year maximum	100%, up to a maximum of $50 per visit These expenses are subject to the overall benefit year maximum
Podiatrists or chiropodists	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Chiropractors	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Osteopaths or osteopathic practitioners	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum

Audiologists	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Dieticians	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Occupational therapists	Not covered	85% subject to the overall benefit year maximum	100% subject to the overall benefit year maximum
Vision care	Not covered	85% $250 per person over 2 benefit years These expenses are subject to the overall benefit year maximum	100% $400 per person over 2 benefit years These expenses are subject to the overall benefit year maximum
Lock-in period	1 year	1 year To decrease your coverage – 2 years	2 years
Benefit year	January 1 to December 31		
Changes in options	Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change.* You can only move down by one option at a time however, you can move up by more than one option at a time. Proof of good health is not required.		
Coverage ends	When you retire. Coverage may also end on an earlier date, as specified in *General Information*.		

Your Dental Care options

	Option 1	Option 2	Option 3
Deductible per benefit year	Individual – $50 Family – $100	Individual – $50 Family – $100	Individual – $50 Family – $100
Preventive	80%	85%	100%
Frequency of visit	1 every 9 months	1 every 9 months	1 every 6 months
Basic	50%	85%	100%
Major	Not covered	50%	70%
Orthodontics	Not covered	Not covered	50%

Benefit year maximum	$750 for Preventive and Basic combined	$1,500 for Preventive, Basic and Major combined	$2,000 for Preventive, Basic and Major combined
Lifetime maximum	Not applicable	Not applicable	$2,500 for Orthodontics
Lock-in period	1 year	1 year To decrease your coverage – 2 years	2 years
Benefit year	January 1 to December 31		
Changes in options	Subject to the *lock-in period* indicated above, you can change your option during the annual enrolment period or within 31 days of a *life event change*. You can only move down by one option at a time however, you can move up by more than one option at a time. Proof of good health is not required.		
Coverage ends	When you retire. Coverage may also end on an earlier date, as specified in *General Information*.		

Your Health Spending Account

Benefit year	January 1 to December 31
Plan credits	Remaining CAE SELECT Dollars based on your allocation decision on the commencement of each benefit year
	If your coverage starts after the commencement of the benefit year, your plan credits are adjusted by the employer for that benefit year. If you need additional information, please contact your employer.
Coverage ends	When you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Your Personal Spending Account

Benefit year	January 1 to December 31
Plan credits	Remaining CAE SELECT Dollars based on your allocation decision on the commencement of each benefit year
	If your coverage starts after the commencement of the benefit year, your plan credits are adjusted by the employer for that benefit year. If you need additional information, please contact your employer.
Coverage ends	When you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Your Long-Term Disability options

	Basic	Option 1	Option 2	Option 3
Coverage	50% of your monthly basic earnings	75% of your monthly basic earnings	50% of your monthly basic earnings	60% of your monthly basic earnings
Maximum	$15,000	$15,000	$15,000	$15,000
Proof of good health	Approval required for coverage in excess of $11,000 and any increase in that coverage of 25% or more or $500, whichever is greater.			
Taxability	Taxable	Taxable	Non taxable	Non taxable
Cost of living adjustment ***(after you have been totally disabled for an uninterrupted period of 2 years)***	Not included	Based on the increase in the Canadian Consumer Price index up to a maximum of 3%.	Not included	Based on the increase in the Canadian Consumer Price index up to a maximum of 3%.
Lock-in period	1 year	1 year	1 year	1 year
Changes in options	You can change your option selections during the annual enrolment period or within 31 days of a *life event change*. Proof of good health is not required.			
Coverage ends	When you reach age 65, less the elimination period of 26 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.			

Employee Optional Critical Illness

Amount	You can choose coverage in units of $10,000 Maximum – $250,000 Minimum – $20,000
Proof of good health	Proof of good health will be required when you request optional coverage and any increase in that coverage, except for the first $50,000 if the request is made within 31 days of eligibility. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.
Termination	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.

Spouse Optional Critical Illness

Amount	You can choose coverage in units of $10,000 Maximum – $250,000 Minimum - $20,000
Proof of good health	Proof of good health for your spouse will be required when you request optional coverage for your spouse and any increase in that coverage, except for the first $50,000 if the request is made within 31 days of eligibility. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.
Termination	When you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*. In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.

Your Basic Life coverage

Coverage	1 times your annual basic earnings, rounded to the next higher $1
Maximum	The maximum amount of coverage for your basic, supplemental and optional benefits combined is $1,200,000
Proof of good health	Not required
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Supplemental Life coverage

Coverage	As elected by the employee, 1 times your annual basic earnings, rounded to the next higher $1
Maximum	The maximum amount of coverage for your basic, supplemental and optional benefits combined is $1,200,000
Proof of good health	Required on all supplemental amounts
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Your Optional Life coverage

Coverage	As elected by the employee, 1, 2, 3, 4, 5 or 6 times your annual basic earnings, rounded to the next higher $1

Maximum	The maximum amount of coverage for your basic, supplemental and optional benefits combined is $1,200,000
Proof of good health	Required on all optional amounts
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Coverage	As elected by the employee, units of $25,000
Maximum	$250,000
Proof of good health	Proof of good health of your spouse is required
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your children

Coverage	As elected by the employee, units of $5,000
Maximum	$25,000
Proof of good health	Not required
Coverage ends	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

General Information

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or administrator.

About this booklet

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

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

For administrative purposes, number 105289 will be used for the Critical Illness benefit under this contract.

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

The contract holder, CAE Inc., has entered into an Administrative Services Contract with Sun Life for the Health Spending Account benefit. The contract self-insures this benefit. This means the contract holder has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

In addition, the contract holder has established a Personal Spending Account and entered into a Personal Spending Account Services Contract with Sun Life. The contract holder has the sole legal and financial liability for the Personal Spending Account and Sun Life only acts as administrator.

Long-Term Disability, Critical Illness and Life benefits are insured under contract number 56289. Extended Health Care, Dental Care and Health Spending Account benefits are insured under contract number 25289.

Eligibility

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

- you are a permanent, non-seasonal employee.
- you are actively working for your employer at least 20 hours a week.
- you have completed the waiting period.

There is no waiting period for your group plan.

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

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse and who has been living with you in a marital relationship for at least the last 12 months, is an eligible dependent. There is no minimum cohabitation period if a child

is born out of your 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 not married or in any other formal union recognized by law, and are under age 18.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 as long as the child is entirely dependent on you for financial support.

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

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

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

Enrolment

To enrol, you must supply the appropriate enrolment information to your employer within 31 days after the date you become eligible. If your enrolment request is not received by your employer within the 31 day period, you will be covered under the ***Basic*** coverage for Extended Health Care, Long-Term Disability and Basic Life coverage. For a dependent to receive coverage, you must request dependent coverage.

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for Extended Health Care or Dental Care coverage under this plan within 31 days of the date the comparable coverage ends.

Normally, you request Dental Care coverage for yourself or your dependents within 31 days of becoming eligible for coverage. If you do not request coverage within this time limit, the late applicant maximum indicated in the Dental Care provision will apply.

For your Optional Life coverage, your Supplemental Life coverage and your Spouse Optional Life coverage, proof of good health will be required when you request Optional Life coverage or Supplemental Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

For Optional Critical Illness coverage, proof of good health will be required as specified in the *Critical Illness* section. For any coverage that requires proof of good health, coverage will not take effect before Sun Life approves the proof of good health.

When coverage begins

For Dental care, your coverage begins on the later of the following dates:

- the date you become eligible for coverage.
- the date your employer receives your enrolment information for coverage.

For all other benefits, your coverage begins on the date you become eligible for coverage.

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

For Dental care, 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.

For all other benefits, dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

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

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

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

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

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage. For example, your employment status may change, or your employer may change the group contract.

For changes requested due to a *life event change*, subject to the exceptions below, the change in coverage is effective on the date the request is received but not before the actual date of the *life event change*.

All other changes in the coverage will take effect on the date of the change in circumstances.

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

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the

date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

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

When coverage ends

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

dates:

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

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

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

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

Replacement coverage

The group contract will be interpreted and administered according to all legislation concerning the continuation of insurance following contract termination and the replacement of group insurance.

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

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

With respect to Critical Illness, for coverage for any covered condition which was not included in the previous group plan, refer to the Critical Illness benefit provision.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. For Critical Illness claims, you should contact Sun Life to get the proper form to make a claim. For all other claims, you should contact your employer to get the proper form to make a claim.

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

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

Legal actions for insured benefits

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.

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

Proof of disability

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

days of the request, you will not be entitled to benefits.

Coordination of benefits

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

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

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

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

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

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

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order applies:
  - the plan where the person is covered as an active full-time employee.
  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

- the plan where the child is covered as an employee.

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

Definitions

Here is a list of definitions of some terms that appear in this employee

benefits booklet. Other definitions appear in the benefit sections.

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

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

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

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

Enrolment period As determined by your employer, the enrolment period is every year starting in 2012.

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.

Life event change Life event changes include:

- marriage or any other formal union recognized by law, or common-law,
- birth or adoption of a child,
- divorce or legal separation,
- loss of spouse's benefit coverage, or
- death of a dependent.

Lock-in period The minimum time that you must remain with your chosen option. Normally, this is one plan year, unless you experience a *life event change*. For some options, the lock in period is two years.

Salaried employees All non-union employees other than Designated Corporate Executives of CAE – St-Laurent.

Retirement date If you are totally disabled, your retirement date is your 65th birthday,

unless you have actually retired before then.

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

Extended Health Care
(Medicare Supplement)

Insurer

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

General description of the coverage

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

Benefit year

The benefit year is indicated in the Benefit Details section.

Deductible

The deductible is indicated in the Benefit Details section.

Prescription drugs

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*.

We will cover the cost of the following drugs and supplies, after you pay the deductible, that are prescribed by a doctor or dentist and are obtained from a pharmacist. The reimbursement levels are indicated under each option in the Benefit Details section.

- drugs and oral contraceptives that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a maximum of $650 per person per benefit year.
- intrauterine devices (IUDs), diaphragms, contraceptive patches and contraceptive delivery systems.
- drugs for the treatment of infertility, up to a lifetime maximum of $5,000 for each person.
- vaccines, up to the maximum amounts indicated under each option in the Benefit Details section.
- anti-obesity drugs, up to a maximum of $500 per person per benefit year.
- colostomy supplies.
- varicose vein injections.

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

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.

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

Drug evaluation

The following drugs will be evaluated and must be approved by us to be eligible for coverage:

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar conditions(s).

- plan sustainability.

Pharmaceutical services (rendered by pharmacists)

We will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

Prior authorization program

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

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

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

Out-of-pocket maximum

Expenses incurred for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary and not reimbursed under this plan as a result of the application of the deductible or the reimbursement level are limited in each calendar year to the yearly maximum contribution set by the RAMQ plan. There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the employee.

Persons age 65 or over residing in Québec

Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the public prescription drug insurance plan of the Régie de l'assurance-maladie du Québec (RAMQ), which provides basic coverage for prescription drugs costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be insured by either the public plan or your group plan.

If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium.

On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact your benefits administrator to clarify your situation. Unfortunately, we cannot change your file without confirmation from your benefits administrator.

Other health professionals allowed to prescribe drugs

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

Hospital expenses in your province

We will cover the costs for hospital care in the province where you live. The reimbursement level is indicated under each option in the Benefit Details section.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and the hospital room indicated under each option in the Benefit Details section.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as:

- it follows at least 3 consecutive days of in-patient hospitalization,
- it is primarily for rehabilitation and not for custodial care.

The reimbursement level is indicated under each option in the Benefit Details section. The maximum amount payable is the difference between the cost of a ward and the hospital room indicated under each option in the Benefit Details section.

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

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

for any of these purposes in a hospital.

Chronic care hospital

We will cover the cost of room and board in a hospital for chronic care treatment. The reimbursement level is indicated under each option in the Benefit Details section.

The maximum amount payable is the difference between a ward and the hospital room indicated under each option in the Benefit Details section. The maximum amount we will pay per day is also indicated under each option in the Benefit Details section.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require 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 or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

Nursing home

We will cover the cost of room and board in a nursing home, provided that the provincial health care plan pays a daily allowance for the confinement. The reimbursement levels and the maximum amounts are indicated under each option in the Benefit Details section.

A *nursing home* is a facility licensed as such to provide care for patients who require assistance with daily living activities, who cannot be cared for at home and who require regular medical supervision and skilled nursing care on a 24-hour basis. It does not include a rest home, home for the aged, chronic care hospital, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

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. The reimbursement levels and the maximum amounts are indicated under each option in the Benefit Details section.

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

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

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you live, subject to the reimbursement level and all conditions applicable to those expenses.

Emergency services

We will only cover emergency services obtained within 6 months of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when you are medically stable to return to the province where you live.

Emergency services excluded from coverage

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

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

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Medical services and equipment

We will cover the cost for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order). The reimbursement levels are indicated under each option in the Benefit Details section.

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or 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 can not perform the duties. The reimbursement level and the maximum amount we will pay are indicated under each option in the Benefit Details section.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically

necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses. The reimbursement levels and the maximum amounts we will pay are indicated under each option in the Benefit Details section.
  - laboratory tests.
  - ultrasounds.
  - MRI (magnetic resonance imaging), CT (computed tomography) scans, x-rays, thermographies, mammographies and electrocardiograms.
  - sleep apnea tests.
  - for employees residing in Québec, laboratory tests performed by Dynacare, at your workplace.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must begin within 60 days of the accident and must be completed within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, limited to one examination per person in a benefit year.
- surgically implanted intraocular lenses, including 1 pair of eyeglasses or contact lenses following eye surgery.

- wigs following chemotherapy, up to a lifetime maximum of $200 per person. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair, including rechargeable batteries for wheelchairs. The reimbursement levels are indicated under each option in the Benefit Details section.
- wheelchair cushion**,** up to the reimbursement levels indicated under each option in the Benefit Details section.
- mechanical or hydraulic patient lifters. The reimbursement levels and the maximum amounts we will pay are indicated under each option in the Benefit Details section.
- outdoor wheelchair ramps, up to a lifetime maximum of $2,000 per person.
- hospital bed, excluding Craftmatic beds, rented, or purchased at our request, up to the reimbursement levels indicated under each option in the Benefit Details section. Repairs are included in this maximum.
- living aids (elevated toilet seats, shower chairs, bathtub rails and standard commodes), up to the reimbursement levels indicated under each option in the Benefit Details section.
- TENS machine, up to a lifetime maximum of $700 per person.
- therapeutic mattress, up to the reimbursement levels indicated under each option in the Benefit Details section.
- prone standers.
- casts, splints, trusses, braces or crutches.

- breast prostheses required as a result of surgery, up to a maximum of 1 per breast per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes, including replacement and repair, up to a combined maximum of $10,000 per person per benefit year.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose. The reimbursement levels and the maximum amounts we will pay are indicated under each option in the Benefit Details section.
- custom-made orthotic inserts for shoes, orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist, chiropodist or chiropractor. The reimbursement levels and the maximum amounts we will pay are indicated under each option in the Benefit Details section.
- extremity pumps, up to a lifetime maximum of $1,500.
- hearing aids prescribed by an ear, nose and throat specialist. The reimbursement levels and the maximum amounts we will pay are indicated under each option in the Benefit Details section. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a doctor, up to a maximum of one glucometer per person over a period of 4 benefit years.
- coaguchek equipment, including replacements, prescribed by a cardiac surgeon or hematologist when an anticoagulant drug is prescribed, up to a maximum of $1,000 per person over a period

of 5 benefit years. The supplies required with this equipment are covered without a maximum.

- insulin pumps, up to the reimbursement levels indicated under each option in the Benefit Details section.

Paramedical services

We will cover the costs for paramedical specialists listed below. The reimbursement level and the maximum amount we will pay per person in a benefit year are indicated under each option in the Benefit Details section.

- licensed psychologists, licensed social workers, licensed psychotherapists, or psychotherapists who are active members of a provincial association which is approved by Sun Life.
- licensed massage therapists ***(services must be ordered by a doctor)***.
- licensed speech therapists.
- licensed physiotherapists.
- licensed acupuncturists.
- licensed audiologists.
- licensed dieticians.
- licensed occupational therapists.
- licensed osteopaths or osteopathic practitioners, including x-ray examinations.
- licensed chiropractors, including x-ray examinations.
- licensed podiatrists or chiropodists, including x-ray examinations.

We will not pay for the cost of services rendered by a podiatrist in Alberta unless they are performed after the provincial medicare plan

has paid its annual maximum benefit.

Vision care

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

The reimbursement level and the maximum amount payable per person over a 2 year period are indicated under each option in the Benefit Details section.

An additional lifetime maximum of $360 is available for contact lenses prescribed as a result of a severe corneal astigmatism, a severe corneal scar, a keratoconous (conical cornea) or an aphakia, and the visual acuity cannot reach the 20/40 level with prescription eye glasses.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.

Payments after coverage ends

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

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

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

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the

procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

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

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

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

Integration with government programs

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

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

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

When and how to make a claim

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

In order for you to receive benefits, we must receive the claim no later than the earlier of the following dates:

- 15 months after the date you incur the expenses,
- 15 months after the date your Extended Health Care coverage ends, or
- 90 days after the date the contract ends.

Emergency Travel Assistance

Insurer

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

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (*Allianz Global Assistance*) can help.

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 Extended Health Care coverage. It only covers emergency services that you obtain within 6 months of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

The Medi-Passport coverage is subject to any maximum applicable to the emergency portion of the Extended Health Care benefit. The emergency services excluded from coverage, and all other conditions, limitations and exclusions applicable to your Extended Health Care coverage also apply to Medi-Passport.

We recommend that you bring your Travel card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.

Getting help

At the time of an emergency, you or someone with you must contact Allianz Global Assistance. If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have

been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.

The maximum amount advanced will not exceed $10,000 per person per trip unless this limit will compromise your medical care.

Reimbursement of expenses

If, after obtaining confirmation from Allianz Global Assistance that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.

To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Allianz Global Assistance:

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.

- amounts paid for services or supplies not covered by this plan.
- amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

Limits on Emergency Travel Assistance coverage

There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure.

Allianz Global Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- the refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Allianz Global Assistance

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

Dental Care

Insurer

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

General description of the coverage

In this section, *you* means the employee and all dependents covered for Dental Care benefits.

Dental Care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

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

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

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a

separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

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

The benefit year is indicated in the Benefit Details section.

Deductible

The deductible is indicated under each option in the Benefit Details section.

Benefit year maximum

The maximum amount we will pay per person per benefit year is indicated under each option in the Benefit Details section.

Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is indicated under each option in the Benefit Details section.

Predetermination

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

Preventive dental procedures

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

The reimbursement level is indicated under each option in the Benefit Details section.

Oral examinations

1 complete examination every 24 months.

1 recall examination, the frequency of visits is indicated under each option in the Benefit Details section.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 24 months.

1 set of bitewing x-rays, the frequency of visits is indicated under each option in the Benefit Details section.

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

Other services

Required consultations between two dentists.

Consultations between patient and dentist with regard to sleep apnea.

Polishing (cleaning of teeth) and topical fluoride treatment, the frequency of visits is indicated under each option in the Benefit Details section.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction, the frequency of visits is indicated under each option in the Benefit Details section.

Basic dental procedures

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

The reimbursement level is indicated under each option in the Benefit Details section.

Fillings Amalgam, composite, acrylic or equivalent.

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

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

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

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

For scaling and root planing, you are covered up to a combined maximum of 15 units of 15 minutes per benefit year.

For occlusal adjustments and occlusal equilibration, you are covered up to a combined maximum of 4 units of 15 minutes per benefit year.

Oral surgery Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).

Major dental procedures

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

The reimbursement level is indicated under each option in the Benefit Details section.

Major restorations Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).

Repair Repair of bridges or dentures.

Rebase or reline Rebase or reline of an existing partial or complete denture.

Prosthodontics Construction and insertion of bridges or standard dentures. Coverage is limited to teeth extracted while you are covered under this plan. Charges for a replacement bridge or replacement standard denture are

not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

- it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.
- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Orthodontic procedures

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

Only children under age 19 are covered for these procedures.

The reimbursement level and maximum are indicated under each option in the Benefit Details section.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

Payments after coverage ends

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

What is not covered

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

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

We will not pay for:

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

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion. However, this restriction does not apply if the accident occurs while covered during the course of any business trip for the employer.

- teeth malformed at birth or during development.
- participation in a criminal offence.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive the claim no later than the earlier of the following dates:

- 15 months after the date you incur the expenses,
- 15 months after the date your Dental Care coverage ends, or
- 90 days after the date the contract ends.

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

Health Spending Account

Plan administrator

This benefit is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

Your Health Spending Account coverage pays for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependent is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

Benefit year

The benefit year is indicated in the Benefit Details section.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one benefit year cannot be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year following the benefit year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Credits

Your credits are indicated in the Benefit Details section.

If your coverage starts after the commencement of the benefit year, your plan credits are adjusted by the employer for that benefit year. If you need additional information, please contact your employer.

Eligible expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act (Canada) **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act (Canada) is changed, this plan is automatically updated to reflect the changes.

Drugs

- drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses

- eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances

- deductible and coinsurance amounts under medical or dental plans.

Licensed practitioners (fee for services)

- acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapeutists.

Dental care

- preventative, diagnostic, restorative, orthodontic and therapeutic care.

Attendant care

- remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.

- remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.

Facilities

- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.

- payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.

Hospitals

- payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.
- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of $1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.

- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind

individuals to enable them to read print.

- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
- costs of medical services and supplies outside of the province of

residence.

- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
  - equivalent medical services are not available locally.
  - the route is reasonably direct.
  - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

If you or your eligible dependents have coverage under another plan, you should submit your claims to the other plan first. Once benefits

have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

When and how to make a claim

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

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

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

Personal Spending Account

Administrator

This Personal Spending Account is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has established a Personal Spending Account and has the sole legal and financial liability for this Personal Spending Account under the Personal Spending Account Services Contract entered into with Sun Life. Sun Life only acts as administrator.

Your employer will be responsible for all payroll related deductions and issuing the appropriate tax information slips related to your Personal Spending Account.

Your Personal Spending Account coverage provides reimbursement to you for expenses described in this section under *Eligible expenses*.

An eligible expense is incurred on the date the expense is billed. Eligible expenses incurred by your dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Personal Spending Account and before the date the Personal Spending Account ends.

Your dependent must be your spouse or your children and any other member of your family or your spouse's family who are dependent on you for financial support, such as parents, grandparents or grandchildren, and a resident of Canada or the United States. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care or Dental Care benefits.

Benefit year

The benefit year is indicated in the Benefit Details section.

How your Personal Spending Account works

Your Personal Spending Account works like an expense account. Your employer will allocate credits to your Personal Spending Account in the manner described under *Credits*.

Each time you submit a Personal Spending Account claim, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Personal Spending Account.

If your coverage ends and this provision is not terminated, you have 90 days to request the payment to you of any balance in your Personal Spending Account.

Balance carry-forward

This Personal Spending Account is set up with a ***balance carry-forward*** feature. This means that you may be reimbursed for eligible expenses incurred in a benefit year using credits received during that benefit year, as well as any unused credits that have been carried forward from the previous benefit year.

In other words, any credits remaining in your Personal Spending Account at the end of one benefit year will be carried forward and may be used to reimburse you for eligible expenses incurred in the following benefit year. Credits that are carried forward from one benefit year to the next will be lost at the end of the second benefit year if you have not used them by then. Carried forward credits are always used before new credits are used.

We must receive claims for eligible expenses incurred in a benefit year no later than 15 months after the end of the benefit year during which the eligible expenses are incurred, or 90 days after your Personal Spending Account coverage ends, whichever is earlier. Please see *When and how to make a claim*.

Credits

Your credits are indicated in the Benefit Details section.

If your coverage starts after the benefit year begins, your credits are adjusted by the employer for that benefit year. If you need additional information, please contact your employer.

Eligible expenses

You can use your Personal Spending Account to help you pay for the following eligible expenses:

Fitness services

- fitness club or gym memberships.

- registration fees for fitness-related programs, lessons or courses (such as aerobics, yoga, dance and martial arts).
- sports team memberships and registration fees.
- annual memberships or daily passes to athletic facilities (such as golf courses, racquet clubs and ski hills).
- personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.
- registration fees for fitness-related events (such as walks, runs and races).
- recreational activity fees (such as boating fees, camping fees and trail passes).
- fees for athletic facilities and equipment rental costs.
- fitness-related apps, software and programs.
- hunting and fishing licenses.

Fitness equipment

- purchase or rental of exercise equipment (such as treadmills, exercise bikes, universal gyms and weights).
- specialized sports equipment (such as skates, bikes, non-motorized boats, rackets and clubs).
- fishing gear and supplies, camping gear, tents and sleeping bags.
- jogging or cycling strollers.
- specialized athletic footwear (such as running shoes, golf shoes and swim fins).
- fitness-related apparel (such as running jackets, cycling shorts and swim caps).

- athletic safety equipment (such as helmets, eye protection and mouthguards).
- fitness tracking tools (including watches) and heart-rate monitors.
- fitness consoles and accessories, DVDs and downloadable work-out videos.

Health products and services

- weight management programs (excluding food).
- nutrition programs and counselling.
- cholesterol and hypertension screening.
- smoking cessation programs and products.
- services provided by iridologists, herbalists, Chinese medical practitioners and acupressurists.
- other alternative wellness services (such as Reiki, Rolfing and light therapy).
- stress management programs.
- first aid and CPR (cardiopulmonary resuscitation) training.
- health, fitness or lifestyle assessments.
- vitamins and supplements, including herbal products.
- sleeping aids (such as orthopaedic mattresses and pillows, darkening blinds, white noise machines and ear plugs).
- medical alert products and services.
- personal care items (such as heating pads, thermometers, sunscreen, teeth whitening kits and denture products).
- life coach services or fees for spiritual or wellness retreats (excludes the cost of travel and accommodations).

- cosmetic procedures (such as Botox, dermabrasion and tattoo removal).
- health-related apps, software and programs.
- day-spa services (such as baths, saunas and aesthetic treatments).

Education and personal development

- tuition fees for university, college or continuing education (including books and supplies).
- fees for language training and tutoring.
- fees or dues for professional memberships or associated with maintaining a professional designation.
- hobby or general interest classes and supplies (including cameras).
- personal computers, accessories and software.
- online courses offered through a recognized educational institution requiring registration.
- internet services (statements used as receipts must include payment amounts and dates).
- cultural activity passes or tickets (for things like museums, zoos, music concerts, plays, operas and symphonies).
- lessons, courses, seminars and conferences (including books, instruments, supplies and accessories).
- reading materials and book club memberships (including e-readers and books).
- finance-related apps, software and programs.
- smartphones and tablets.

Green living

- public transit passes.

- solar energy and wind energy products.
- energy home audits, cost to upgrade windows, programmable thermostats and weather stripping.
- lead pipe and asbestos removal from home.
- composters, rain barrels, recycling bins and recycling fees for atypical items (such as electronics).
- appliances certified as energy efficient and other energy efficient products for home heating, cooling and lighting (such as tankless water heaters and compact fluorescent light bulbs).
- car or bike sharing memberships and usage fees (excluding fuel costs and repair fees).

Work-life balance

- childcare expenses.
- elder-care expenses.
- pet-care services (such as kenneling, obedience training, dog walking and veterinarian fees).
- domestic services (such as house cleaning, snow removal, landscaping and moving services).
- Intelligent Personal Assistant (IPA) devices.

Safety initiatives

- baby safety equipment.
- first aid products (such as bandages, Automated External Defibrillators (AED) and disinfectant).
- smoke alarms, carbon monoxide (CO) detectors, fire extinguishers and fire escape ladders.
- personal protective gear (such as safety boots, eye protection and safety gloves).
- life jackets, bear spray, rescue equipment and avalanche kits.

- home security systems and associated fees.

Professional services

- estate planning, financial investment counselling and tax return preparation.
- legal expenses (such as wills, divorces, and house purchases or sales).

Insurance premiums

- Life and Critical Illness insurance premiums, as well as Long Term Care facility premiums.
- pet insurance premiums.

Financial

- Registered Retirement Savings Plan (RRSP) contributions.
- Registered Education Savings Plan (RESP) contributions.
- Tax-Free Savings Account (TFSA) contributions.

When and how to make a claim

Submit your claims electronically on our website at www.mysunlife.ca.

In order for you to be reimbursed, we must receive the claim no later than:

- 90 days after the end of the benefit year during which the eligible expenses are incurred, or
- 90 days after the end of your Personal Spending Account coverage, whichever is earlier.

Long-Term Disability

Insurer

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

General description of the coverage

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

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

For your Long-Term Disability coverage,

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

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

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

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

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

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 26 weeks or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

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

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 26 weeks and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

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

Step 1: We take the percentage of your monthly basic earnings as indicated in the Benefit Details section. The maximum is also indicated in the Benefit Details section.

Step 2: We subtract any income provided to you:

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

living increases that occur after benefits begin.

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

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

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

Additional sources of income provided to you:

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

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

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

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

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

For options 1 and 3 only – After you have been totally disabled for an uninterrupted period of 2 years, your benefits will be increased on January 1 of each year. The maximum is indicated under each option in the Benefit Details section.

Taxability

If your employer pays any portion of the Long-Term Disability premium, your Long-Term Disability payments are taxable.

If you pay 100% of the Long-Term Disability premium, your Long-Term Disability payments are not taxable.

Maternity / parental leave of absence

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

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

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

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 26 weeks, provided your coverage has been

continued.

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

Partial disability program

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

After you are eligible for Long-Term Disability payments, you may be considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

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

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

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

Rehabilitation program

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

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

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

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

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

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and the initial period of total disability lasts for at least 2 weeks without interruption.

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

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

Interrupted periods of disability after payments begin

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

- 6 months of the end of your previous disability, or
- 24 months after the end of a rehabilitation program approved by Sun Life.

You must be covered when total disability reoccurs.

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

If you recover damages from another person

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

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

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

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

Your responsibilities

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

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

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

When payments end

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

- the date you are no longer totally disabled.

- the date you have found employment after participating in an approved vocational training and provided this occurs within 6 months of the end of such a program.
- the last day of the month in which you reach age 65.
- the last day of the month in which you retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence* or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 6 months during any 12 month period due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if your disability results directly or indirectly from a condition which existed on or before the date your coverage

began. However, this limitation will not apply to you if:

- you have been covered for Long-Term Disability with your employer for at least 13 weeks during which you have been actively working continuously (up to 3 days of absence does not count) and you have not been treated by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- you became totally disabled more than 12 months after your coverage began.

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

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion. However, this restriction does not apply if total disability occurs while covered during the course of any business trip for the employer.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

When and how to make a claim

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

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

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

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

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

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

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

Critical Illness

Insurer

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

General description of the coverage

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

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

What we will pay

The amounts of coverage are indicated in the Benefit Details section.

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

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

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

Diagnosis

Diagnosis means a written diagnosis by a physician or specialist physician, licensed and practicing in Canada, of the covered condition. Any diagnosis must be made while coverage is in force and will be effective as of the date it is established by the physician or specialist physician, as supported by the covered person's medical records. Any diagnosis of a covered condition that was made prior to the effective date

of coverage will not be covered.

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

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

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

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

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

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

Changes in coverage

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

Changes in the amount of coverage

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

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

Other changes

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

- employees who are actively 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.

If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions. If your spouse is hospitalized when the change occurs, the change will take effect when your spouse is discharged and resumes normal activities and such date will be your spouse's effective date of coverage for the new covered conditions.

In all instances, we will:

- apply the effective date of coverage to determine a person's eligibility for a Critical Illness benefit payment; and
- apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions

and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where proof of good health was previously required for a person's coverage.

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

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

Aortic Surgery

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

Exclusion:

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

Aplastic Anemia

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

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

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

Bacterial Meningitis

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

Exclusion:

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

Benign Brain Tumour

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 Sun Life 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

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

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

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

Cancer (Life-threatening)

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

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

Exclusions:

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

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date Sun Life 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

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

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

Exclusions:

No benefit will be payable under this condition for:

- a medically induced coma;

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

Coronary Artery Bypass Surgery

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

Exclusion:

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

Deafness

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

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

Dementia, including Alzheimer's Disease

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

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

The covered person must exhibit:

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

Exclusion:

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

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

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

Heart Valve Replacement or Repair

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

Exclusion:

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

Kidney Failure

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

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

Loss of Independent Existence

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

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by

sponge bath, with or without the aid of assistive devices;

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

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

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

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

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

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

Exclusion:

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

Major Organ Failure on Waiting List

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

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

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

Major Organ Transplant

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

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

Motor Neuron Disease

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

Multiple Sclerosis

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

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

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

Occupational HIV Infection

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

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

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

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

event.

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

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

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

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date Sun Life 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

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

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

Stroke (Cerebrovascular Accident)

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

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

persisting for more than 30 days following 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.

Coverage during total disability

If you become totally disabled while covered and premiums are no longer payable for Life coverage, your Critical Illness coverage will continue without the payment of premiums for as long as premiums are not payable for your Life coverage, but not beyond age 65 or termination of the Critical Illness benefit.

Your spouse's coverage will also continue without the payment of premiums, for as long as premiums are not payable for your Life coverage, but not beyond the date you or your spouse reach age 65 or termination of the Spouse Critical Illness benefit.

If proof of total disability is approved after coverage has been transferred under the Portability clause, the group Critical Illness coverage will be reduced by the transferred amount, unless the transferred coverage is exchanged for a refund of premiums.

Any amount of coverage continued is subject to the terms of this group plan when total disability began.

What is not covered

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

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

- intentionally self-inflicted injuries or attempted suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion. However, this restriction does not apply if the condition occurs while covered during the course of any business trip for the employer.
- 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 Optional coverage that:

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

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

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

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

Portability

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

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

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

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

When and how to make a claim

We must receive notice of claim as soon as reasonably possible after the date of diagnosis or surgery. We 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.

Best Doctors

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

If you or your spouse are covered for Critical Illness, you, your spouse, your children, your parents and your parents-in-law 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. To learn more about Best Doctors services, or to use these services, please call Best Doctors at 1-877-419-BEST (2378).

Liability and responsibility of Sun Life

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

Sun Life cannot guarantee the availability of Best Doctors services.

Life Coverage

Insurer

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

General description of the coverage

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

What we will pay

The amounts of coverage are indicated in the Benefit Details section.

Who we will pay

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

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

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

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

Suicide

If you or your spouse have any optional coverage that has been in

effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

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

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

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

Total disability must continue for:

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

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

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

For the purposes of your Life coverage, you will be considered totally

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

Converting Life coverage

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

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

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

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

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

When and how to make a claim

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

Voluntary Accidental Death and Dismemberment Insurance

Insurer ***This benefit is insured by SSQ Insurance Company Inc.***

INTRODUCTION

What is Accidental Death and Dismemberment insurance?

Accidental Death and Dismemberment insurance offers the financial protection needed in case of an accident to help alleviate financial setbacks for you and your loved ones. Accidental Death and Dismemberment coverage provides payment in the event of an accident resulting in death or serious injury. The amount that is paid will depend upon the type of injury.

Who needs Accidental Death and Dismemberment insurance?

Everyone should plan for their financial security because accidents happen. According to Statistics Canada (2006), unintentional injury is the 5th leading cause of death in Canada. Nowadays, few people set money aside for emergency needs, so this coverage provides you with protection when it is most needed. Not only does Accidental Death and Dismemberment coverage help lighten the financial burden you or your family may experience due to an accident, but most importantly, it will provide you with a peace of mind.

Why should you consider Accidental Death and Dismemberment insurance?

Because no one is immune to accidents, Accidental Death and Dismemberment insurance is perceived as a valuable addition to any group insurance plan. Accidents happen and their impact may be devastating to you and your loved ones. Recovery from an accident may take a while and may cost you more than you'd expect. That is why it is beneficial to make Accidental Death and Dismemberment insurance a part of your group insurance plan, as it provides necessary resources when they are most needed.

What are the advantages of your coverage?

With our group Accidental Death and Dismemberment insurance, you benefit from:

- Comprehensive coverage

- Extensive list of benefits
- 24-hour, year round and worldwide coverage
- Efficient claims service
- Coverage may be used to complement your company group life, health or disability insurance

Definitions – for a better comprehension of this booklet

Wherever used in this booklet:

“Accident” means a sudden and unexpected mishap or event in which an Insured Person is involved and which directly results in an Injury to the Insured Person.

"Accommodation" means lodging at a hotel, motel, inn, bed and breakfast or other like establishment as well as food reasonably required during the lodging, provided however that no indemnity will be paid for lodging at a private residence or for food not consumed as meals by the person seeking reimbursement of expenses.

"Brain Damage" means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.

"Commencement of Total Disability" means the date of commencement of the Insured Person's Total Disability, as determined by a Physician, which date must be subject to the satisfaction of the Insurer that, on that date, the Insured Person has met all criteria for Total Disability.

"Day-Care Centre" means a facility, which is run according to the law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. A Day-Care Centre will not include a hospital, the child's home or school if the only care at such school is provided during normal school hours while the Dependent Child is attending school from grades one (1) through twelve (12).

"Dependent Child" means a natural child, adopted child, stepchild or child with who is in a parent-child relationship with you. The child must be dependant upon you for maintenance and support and:

(1) under 18 years of age; or
(2) under 26 years of age and in attendance at an Institution for Higher Learning on a full-time basis; or
(3) no matter his age on the date of the claim, have been struck with a Functional Disability while satisfying the criteria under paragraphs (1) or (2) above. Proof of existence of this Functional Disability, including the determination by a Physician that the disability exists and when it occurred, must be presented to the Insurer within 31 days after the child reaches the age at which he would otherwise no longer qualify as a Dependent

Child under paragraph (1) or (2) above. Thereafter, the Insurer may periodically require that other proof be submitted establishing to its satisfaction that the Functional Disability still exists and that the child otherwise meets the definition of Dependent Child, failing which, the Insurer may determine that the child no longer qualifies as a Dependent Child under the Policy.

The Dependent Child will be covered from birth, provided such child is born alive.

“Employee” means a Canadian employee of the Policyholder under the age of seventy (70) who occupies a permanent full time (minimum of 20 hours per week) paid position or who is hired on a contractual basis by the Policyholder. The Employee is designated by the terms “you” and “your” for the purposes of this booklet.

"Employee Only Plan" means a plan which provides insurance to the Employee only.

"Employee and Family Plan" means a plan which provides insurance to the Employee and his/her Spouse and/or Dependent Children.

"Fare" means the regular fare charged for:

(1) an economy class seat on a regular flight by a domestic or international scheduled air carrier;
(2) a coach seat on a passenger train;
(3) a regular seat on a passenger bus;
(4) an economy class accommodation on a boat.

Each of those carriers must hold a current and valid certificate issued by Transport Canada or, if subject to regulation in another country by a similar governmental authority having jurisdiction in that country.

"Functional Disability" means an irreversible and serious limitation of a person’s physical or mental capacity or of their skills that prevents the person from living independently.

“Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Hospital" means an institution licensed as a hospital within the jurisdiction in which it operates. To qualify under this definition, a hospital must be an active treatment hospital open at all times for the care and treatment of sick and injured persons, have a staff of one (1) or more Physicians available at all times, provide twenty-four (24) hour nursing service by graduate registered nurses and have organized facilities for diagnostics and surgery. A facility which is primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment is not a Hospital. For the purposes of this definition, a Hospital will include a facility or part of a facility used for rehabilitative care.

“Immediate Family Member” means a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, uncle, aunt, nephew, niece, grandson, granddaughter, grandfather, grandmother (all of the above include natural, adopted or step relationships) or the spouse of an Insured Person.

“Injury” means bodily injury caused by an Accident occurring while the Policy is in force as to the Insured Person whose loss is the basis of claim and resulting directly and independently of all other causes in loss covered under the Policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

"Institution for Higher Learning" means and is limited to universities, colleges, CEGEPs and professional or vocational schools.

“Insurer”, “We”, “Us” means SSQ Insurance Company Inc.

“Insured Person” means you, or your insured Spouse or your insured Dependant Children, while meeting the Spouse and Dependent Child definition criteria presented in this section, and before the date of individual coverage termination.

"Intoxicated" and "Under the Influence of Drugs" means that the driver has a blood alcohol content and/or is impaired due to the use of alcohol, narcotics or other drugs such that he could be subject to proceedings under provincial, state or federal law, even if he has not been subject to such proceedings.

“Loss of Life” means the death of the Insured Person.

“Loss” means:

(a) as used with reference to a hand or foot, the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;
(b) as used with reference to an arm or leg, the complete and irrecoverable severance through or above the elbow or knee joint;
(c) as used with reference to a thumb, the complete and irrecoverable severance of one (1) entire phalanx of the thumb;
(d) as used with reference to a finger, the complete and irrecoverable severance of two (2) entire phalanges of the finger;
(e) as used with reference to toes, the complete and irrecoverable severance of one (1) entire phalanx of the big toe and irrecoverable severance of all phalanges of the other toes;
(f) as used with reference to an eye, the irrecoverable loss of the entire sight thereof, and determined by a Physician to be irrecoverable;

(g) as used with reference to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds, and determined by a Physician to be irrecoverable;
(h) as used with reference to hearing, the complete and irrecoverable loss of hearing, and determined by a Physician to be irrecoverable.

“Loss of Use” means a total incapacity to use part of the body, which has been continuous for twelve (12) consecutive months and was determined by a Physician to be permanent at the end of such period.

"Motorized Vehicle" means a passenger car, van, jeep-type automobile, sports utility vehicle (SUV), any truck-type automobile, truck, ambulance, or any type of motorized vehicle used by municipal, provincial or federal police forces.

“On the business of the Policyholder” means any trip on assignment by or with the authorization of the Policyholder for the purposes of furthering the business of the Policyholder.

“Paralysis” means the loss of ability to move all or part of the body.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs of the body.

“Physician” means an individual who is legally licensed to practice medicine and provide treatment within the scope of his licence by:

(a) a recognized medical licensing organization in the jurisdiction where the treatment is rendered, provided he is a member in good standing of such licensing body, or
(b) a governmental agency having jurisdiction over such licensing where the treatment was rendered.

The Physician must not ordinarily reside in the Insured Person's residence. The Physician must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

“Policy” means Policy #1S225 as well as the attached Master Application, any endorsements and attached papers.

“Policyholder” means CAE inc.

“Principal Sum” means the amount indicated at the section “Coverage Amounts” as being applicable to the Insured Person and stated on the Insured Person's most recently signed individual enrollment card on file with the Policyholder, if any.

“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs of the body.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing and recognized standards of medical practice.

"Seat Belt" means a belt that forms a restraint system in a Motorized Vehicle.

For the purposes of this definition, a Seat Belt includes infant and child restraint systems used in Motorized Vehicles and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

“Sickness or Disease” means the alteration of a person’s state of health resulting from internal or external cause(s), creating objectively verifiable symptoms and/or signs, and revealing itself by the impairment of physiological or mental functions.

“Specific Loss” means Loss of Life, Loss, Loss of Use, Quadriplegia, Paraplegia or Hemiplegia, all as defined in this section of this booklet.

"Spouse" means an individual under the age of seventy (70):

(a) to whom you are legally married or in a civil union with; or

(b) with whom you have continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

However, when the individual is the biological or adoptive mother or father of at least one of your children and is cohabitating with you, the individual shall be deemed a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one year of cohabitation.

Only one (1) individual will qualify as your Spouse. If you are legally married or in a civil union but are also cohabiting with an individual as described under Item (b) above, you may elect in writing, which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom you are legally married or in a civil union with.

"Total Disability" or "Totally Disabled" means or directly refers to a continuous state of incapacity preventing the Insured Person from performing all of the usual and customary duties of his occupation.

An Insured Person will be deemed Totally Disabled only if he does not receive any income from any occupation after the Commencement of Total Disability, directly or indirectly, except in the context of a rehabilitation program approved by the Insurer.

For a Total Disability to be recognized, the state of the Insured Person must require Regular Care and Attendance by a Physician or an appropriate specialist. Proof of Regular Care and Attendance must be satisfactory to the Insurer.

"Transportation" means conveyance from one place to another by private or public Motorized Vehicle, bus, train, boat, ferry, airplane or helicopter.

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

DETAILS OF THE PROGRAM

Eligibility

The Accidental Death and Dismemberment insurance program is available to Employees of the Policyholder and their dependents (Spouse and Dependent Children).

As an active and permanent or contractual Employee of the Policyholder, you are eligible under the Accidental Death and Dismemberment insurance program if you workfull-time (minimum of 20 hours per week), are under the age of seventy (70) and fall into one of the following categories:

Class Ia:
All Active, permanent non-unionized Employees of CAE residing in Canada, their eligible spouses residing in Canada or in the United States of America and their eligible Dependent Children residing in Canada or in the United States of America.

Class Ib:
All Active, permanent Employees of CAE Military Aviation Training (CMAT) residing in Canada, their eligible spouses residing in Canada or in the United States of America and their eligible Dependent Children residing in Canada or in the United States of America.

Class Ic:
All Active, permanent Employees of Presagis Canada inc. residing in Canada, their eligible spouses residing in Canada or in the United States of America and their eligible Dependent Children residing in Canada or in the United States of America.

If you are absent from active work for any reason other than bona fide vacation or maternity/parental leave, you will only become eligible upon return to active work.

Your Spouse is eligible for coverage if he or she is under the age of seventy (70) and meets the Spouse definition as presented under the section of this booklet entitled "Definitions – for a better comprehension of this booklet".
Any of your children who meet the definition of Dependent Child as presented under the section of this booklet entitled "Definitions – for a better comprehension of this booklet" are also eligible for coverage.

Note: If you are legally married but also cohabiting with an individual please refer to the Spouse definition for more information.

Coverage Amounts

The Accidental Death and Dismemberment insurance program is a voluntary coverage program for you, you and your Spouse or you and your dependents (Spouse and Dependent Children) **without having to provide any evidence of insurability**.

Employees – From to 8 times the Annual Earnings up to a maximum of $1,200,000

"Annual Earnings" means the annual rate of wage or salary (exclusive of bonuses, commissions and overtime earnings) the Employee was receiving from the policyholder immediately prior to the date of the accident.

Spouses – $25,000 minimum, in units of $25,000, up to a maximum of $250,000

Dependent Children – $5,000 minimum, in units of $5,000, up to a maximum of $25,000

Enrolment and Effective Date of Individual Coverage

Voluntary program

Enrollment
If you wish to adhere to the voluntary Accidental Death and Dismemberment insurance program, you must complete and send the Policyholder a signed enrollment card or complete the online enrollment.

Effective date of individual coverage
With respect to an Employee who sends an enrollment card or completes an online enrollment, or for whom an enrollment card is sent:

- on or before the effective date of the policy, on the effective date of the policy;

- after the effective date of the policy, on the first of the month following or coincident with the date the enrollment card is received by the Policyholder.
- With respect to Spouse and/or Dependent Child:
- on the effective date of the your coverage;
- on the date the Spouse and/or Dependent Child becomes eligible if eligible after the effective date of your coverage;

Individual Coverage Termination

Your coverage terminates on the earliest of the following dates:

(1) the date the Policy is terminated;

(2) the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;

(3) the premium due date coincident with or following the date you give notice of cancellation to the Policyholder;

(4) the premium due date coincident with or following the date you reach seventy (70) years of age;

(5) the premium due date coincident with or following the date you cease to be an active Employee of the Policyholder on account of leave of absence, lay-off, maternity/parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections of this booklet:
   - Waiver of Premium
   - Continuation of Coverage During Approved Leaves
   - Extension of Coverage

Coverage for your insured Spouse and/or Dependent Child terminates on the earliest of the following dates:

(1) the date such person ceases to satisfy the criteria for definition of "Spouse" or "Dependent Child" as presented under the section of this booklet entitled "Definitions – for a better comprehension of this booklet";

(2) the date your coverage is terminated except as provided under the "Extension of Family Coverage" section of this booklet.

PROGRAM BENEFITS

Specific Loss Accident Indemnity

When, within three hundred and sixty-five (365) days after the date of an Accident, an Insured Person suffers an Injury from such Accident which results in a Specific Loss listed below, the Insurer will pay an indemnity as indicated below:

Loss of

Life ..... The Principal Sum
The entire sight of both eyes ..... The Principal Sum
Speech and hearing in both ears ..... The Principal Sum
One hand and the entire sight of one eye ..... The Principal Sum
One foot and the entire sight of one eye ..... The Principal Sum
The entire sight of one eye ..... Three-Fourths of the Principal Sum
Speech ..... Three-Fourths of the Principal Sum
Hearing in both ears ..... Three-Fourths of the Principal Sum
Hearing in one ear ..... Two-Fifths of the Principal Sum
All toes of one foot ..... One-Third of the Principal Sum

Loss or Loss of Use of

Both hands ..... The Principal Sum
Both feet ..... The Principal Sum
One hand and one foot ..... The Principal Sum
One arm ..... Four-Fifths of the Principal Sum
One leg ..... Four-Fifths of the Principal Sum
One hand ..... Three-Fourths of the Principal Sum
One foot ..... Three-Fourths of the Principal Sum
The thumb and index finger or at least four fingers of one hand .....
..... Two-Fifths of the Principal Sum

Paralysis of

Both upper and lower limbs (Quadriplegia) ..... Two Times the Principal Sum
Both lower limbs (Paraplegia) ..... Two Times the Principal Sum
The upper and lower limbs of one side of body (Hemiplegia) .....
..... Two Times the Principal Sum

However, in the case of Quadriplegia, Paraplegia and Hemiplegia, if the Insured Person dies within ninety (90) days after the date of the Accident, the indemnity payable by the Insurer will be limited to the Principal Sum.

Indemnity provided under this section for all Specific Losses sustained by an Insured Person as the result of any one (1) Accident will not exceed the following:

(a) the Principal Sum, with the exception of Quadriplegia, Paraplegia and Hemiplegia; or

(b) with respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum, provided that the Insured Person lives longer than ninety (90) days after the date of the Accident.

Under this section, in no event will the Insurer pay more than two times the Principal Sum as the result of the same Accident, regardless of the combination of losses suffered.

Covered Accidental Death and Dismemberment Benefits

Surgical Reattachment Benefit

If an Injury sustained by an Insured Person results in the complete severance of the Insured Person's limb or appendage or part of either a limb or appendage, and if such severed limb, appendage or part is then surgically reattached to that Insured Person within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, then the Insurer will pay an indemnity to such Insured Person as follows:

(1) Whether or not the Insured Person regains use of the severed limb, appendage or part, the Insurer will pay an indemnity equal to 50% of the indemnity that would have been payable under the section of this booklet entitled "Specific Loss Accident Indemnity" for the Loss of such limb, appendage or part, if the surgical reattachment had not been performed.

(2) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, the Insured Person suffers a total, irrecoverable and permanent Loss of Use of such reattached limb, appendage or part, the Insurer will pay an indemnity as provided under the section of this booklet entitled "Specific Loss Accident Indemnity" for Loss of Use of such limb, appendage or part, less any amount(s) paid or payable under the Surgical Reattachment Benefit section shown under item (1) above.

(3) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, such reattachment fails and the limb, appendage or part must be amputated, the Insurer will pay an indemnity as provided under the section of this booklet entitled "Specific Loss Accident Indemnity" for the Loss of such limb, appendage or part less any amount(s) paid or payable under this Surgical Reattachment Benefit section, under items (1) and (2).

Indemnity payable under this section and the section of this booklet entitled "Specific Loss Accident Indemnity" for any one (1) Insured Person as the result of any one (1) Accident will not exceed the Principal Sum.

Repatriation Benefit

In the event an Insured Person suffers a Loss of Life resulting from Injury more than fifty (50) kilometres from that Insured Person's normal place of residence and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of the body of the deceased Insured Person to a resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased Insured Person, including charges for the preparation of the body for such transportation, not to exceed, in the aggregate, the amount of fifteen thousand dollars ($15,000) for all such expenses paid under this section as a result of one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Education Benefit

In the event you or your insured Spouse suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary tuition fees for any Dependent Child who, on the date of or within the following three hundred and sixty-five (365) days of the Insured Person’s death, is enrolled or enrolls as a full-time student in any Institution for Higher Learning, up to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person’s Principal Sum; or

(b) five thousand dollars ($5,000),

for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of proof satisfactory to the Insurer that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning. Payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board, books or other living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Day-Care Benefit

In the event you or your insured Spouse suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred for Day-Care Centre attendance for any Dependent Child under thirteen (13) years of age at the date of the Insured Person's death and who on the date of or within the following three hundred and sixty-five (365) days after such Insured Person's death, is enrolled or enrolls in a Day-Care Centre, to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person's Principal Sum; or
(b) five thousand dollars ($5,000),

for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled in a Day-Care Centre.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of satisfactory proof that the Dependent Child is enrolled in a Day-Care Centre, but payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

If none of the Insured Person's Dependent Children satisfy the above requirements or the requirements as shown under the section entitled "Education Benefit", the Insurer will pay to your beneficiary the lesser of the following amounts:

(a) five percent (5%) of the deceased Insured Person's Principal Sum; or
(b) two thousand and five hundred dollars ($2,500),

under only one (1) of the policies issued by the Insurer.

Rehabilitation Benefit

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Injury requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expenses that you actually incurred for such program within three (3) years after the date of such loss. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses that you incurred under this section will not exceed fifteen thousand dollars ($15,000) as the result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Workplace Modification and Accommodation Benefit

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active work with the Policyholder, the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder for such equipment and/or modification provided:

(1) The Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs; and
(2) The Policyholder acknowledges in writing that the performance of the essential duties of your job would be compromised in the absence of such modification or accommodation; and

(3) The proposed special adaptive equipment and/or workplace modification have prior written approval by the Insurer.

The Insurer has the right to have you examined by a professional of its choice to evaluate the appropriateness of the proposed modifications and/or equipment.

The indemnity under this section will be paid to the Policyholder once you have returned to active work with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder under this section will not exceed five thousand dollars ($5,000) as a result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Occupational Training Benefit

In the event you suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay the reasonable and necessary expenses actually incurred within the following three (3) years after the date of such loss by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Payment by the Insurer for the total of all expenses incurred by your Spouse under this section will not exceed fifteen thousand dollars ($15,000).

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Permanent Total Disability Indemnity

In the event you suffer an Injury resulting in Total Disability within three hundred and sixty-five (365) days after the date of the Accident causing such Injury, provided such Total Disability was continued over a period of twelve (12) consecutive months following Commencement of Total Disability and is permanent at the end of this period, the Insurer will pay the Principal Sum, less any amount paid or payable as the result of the same Accident under the section of this booklet entitled "Specific Loss Accident Indemnity".

Family Transportation Benefit

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the bedside of such Insured Person by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route if the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless such Insured Person is confined as an inpatient in a Hospital located more than fifty (50) kilometres from his normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to the bedside of the Insured Person while in Hospital. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars (15 000$) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Identification Benefit

In the event an Insured Person suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and the police or similar governmental authority requires identification of the Insured Person's body, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the location of the Insured Person's body by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route, if, at the time of death, the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless the Insured Person's body is located more than fifty (50) kilometres from the Insured Person's normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to identify the deceased Insured Person. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars (15 000$) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Seat Belt Benefit

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity", the Insurer will pay an additional indemnity equal to ten percent (10%) of the applicable indemnity payable under the section of this booklet entitled "Specific Loss Accident Indemnity", subject to a maximum of fifty thousand dollars ($50,000), if at the time of the Accident causing such Injury, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt. The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

At the time of the Accident, the driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Motorized Vehicle and neither be Intoxicated nor Under the Influence of Drugs.

Proof of Seat Belt use to the satisfaction of the Insurer must be provided as part of the written proof of loss.

Home Alteration and/or Vehicle Modification Benefit

In the event an Insured Person suffers a Specific Loss listed below resulting from an Injury:

(1) Loss of both feet or legs; or
(2) Loss of Use of both feet or legs; or
(3) Quadriplegia, Paraplegia or Hemiplegia,

and indemnity for such loss becomes payable under the section of this booklet entitled "Specific Loss Accident Indemnity" and such Insured Person requires the use of a wheelchair, as result of such loss, in order to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person within three (3) years following the date of Loss for home alteration and/or vehicle modification as provided under this section.

To be covered under this section, the alteration or modification must enable the Insured Person to access his residence and/or his vehicle in a wheelchair and must be approved, where required by law, by licensing authorities.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars ($15,000) as a result of any one (1) Accident.

The amount payable under this section will be co-ordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Aircraft Coverage

Insurance provided under the Policy includes coverage for loss when such loss results from Injury sustained while and as a result of the Insured Person:

A. If the Injury is sustained while the Employee is not performing the normal and regular duties which pertains to his/her occupation.
   (a) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot's license of a rating authorizing him to pilot such aircraft.
   (b) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.
   (c) boarding or alighting from or being struck by any aircraft.

However, coverage is excluded from Injury sustained while and as a result of riding in or on any aircraft owned, operated, leased or chartered by or on behalf of the Policyholder.

B. If the Injury is sustained while performing the normal and regular duties which pertains to his/her occupation.
   (a) riding as a passenger or as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot's license of a rating authorizing him to pilot such aircraft.
   (b) riding as a passenger or as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.
   (c) boarding or alighting from or being struck by any aircraft.

Exposure and Disappearance Coverage

In the event an Insured Person undergoes unavoidable exposure to natural elements and, as a direct result, suffers a Specific Loss for which indemnity would have been payable under the section of this booklet entitled "Specific Loss Accident Indemnity" if it had been caused by an Accident, the Insurer will pay the amount specified for the same loss as in the section of this booklet entitled "Specific Loss Accident Indemnity".

In the event an Insured Person is not found within one (1) year following the date of the disappearance or sinking or wrecking of the conveyance in which he was riding at the time of such disappearance or sinking or wrecking and under such circumstances as would otherwise be covered under the section of this booklet entitled "Specific Loss Accident Indemnity", it will be presumed the Insured Person suffered a Loss of Life resulting from an Injury at the time of such disappearance, sinking or wrecking.

Brain Damage Benefit

In the event an Insured Person suffers Brain Damage as a result of an Injury, the Insurer will pay the Principal Sum, less any other amount paid or payable under the section of this booklet entitled "Specific Loss Accident Indemnity" as the result of the same Accident, provided:

(1) The Insured Person incurs Brain Damage within one hundred and twenty (120) days from the date of the Accident; and
(2) The Insured Person is hospitalized as a result of Brain Damage at least seven (7) of the first one hundred and twenty (120) days of the Injury; and
(3) A Physician determines and the Insurer is satisfied that the Insured Person has evidence of Brain Damage for at least six (6) consecutive months.

Extension of Coverage

Your individual coverage will be continued for a period of up to twelve (12) months if your employment has been terminated by the Policyholder provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement that you received from the Policyholder and payment of premium is continued. Under such conditions, individual coverage with respect to your insured Spouse and/or insured Dependent Children will also continue, provided payment of premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date you return to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer or if required by law.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable to you at the date of termination of employment.

Extension of Family Coverage

In the event of your death from any cause, individual coverage under the Policy will be continued for your insured Spouse and/or insured Dependent Children for a period of six (6) months, without payment of premium.

Indemnities which become payable as a result of coverage being extended under this section will be paid to your insured Spouse, except in the event of the Loss of Life of your insured Spouse, where indemnity for such loss will be paid to the estate of your insured Spouse.

In the event you do not have an insured Spouse, indemnities payable with respect to your insured Dependent Children will be payable as follows:

(a) If your Child is a minor and the loss is not the Loss of Life of your Child, all indemnities payable will be paid in trust to the legal guardian of your Child.
(b) If your Child is not a minor and the loss is not the Loss of Life of that Child, all indemnities payable will be paid to your Child.
(c) Regardless of the age of your Child, the indemnity payable in the event of the Loss of Life of your Child will be paid to the estate of your Child.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following the completion of a six (6) month period which began on the date of your death.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of your death, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable to the Insured Person prior to the date of your death.

Continuation of Coverage during Approved Leaves

Individual coverage under the Policy will be continued for you and your insured Spouse and/or your insured Dependent Children during any of the following:

- your approved leave of absence;
- your temporary lay-off;
- your maternity/parental leave; or
- your disability leave,

provided payment of premium is continued.

This continuation of coverage will terminate at 12:01 a.m., Standard Time:

(1) with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a three (3) month period that started on the date such approved temporary lay-off began or on the date you return to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of three (3) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

(2) with respect to any maternity/parental leave approved by the Policyholder, on the date you return to work in any capacity for the Policyholder or any other employer, including self-employment;

(3) with respect to any disability leave approved by the Policyholder, on the date you reach seventy (70) years of age, qualify under the Waiver of Premium section of this booklet or return to work in any capacity, whichever is earlier; and

(4) with respect to any other leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a thirty (30) day period that started on the date such approved leave of absence began or on the date you return to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of thirty (30) days may be granted, provided written request is submitted by the Policyholder to the Insurer.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable to you at the date of commencement of your leave.

Waiver of Premium

When, under the Policyholder's basic group life insurance policy, your life insurance coverage is extended under a waiver of premium provision as the result of total disability resulting from a Sickness or Disease, from a Sickness or Disease related to pregnancy, from an Injury or from an Accident, coverage under the Policy will also be extended and waiver of premium granted. Premiums with respect to your insured Spouse and insured Dependent Children, if any, will also be waived whenever your premiums are waived.

Premiums will continue to be waived until the earliest of the following dates:

(a) the date the Policy is terminated; or
(b) the date you reach seventy (70) years of age; or
(c) the date the you cease to be totally disabled; or
(d) the date you fail to provide proof satisfactory to the Insurer of the continuance of total disability within ninety (90) days of request of such proof or refuse to submit to a medical examination requested by the Insurer.

The coverage which is continued under this section is subject to the terms and provisions of the Policy which are in effect on the date prior to the commencement of total disability, including any provision providing for reductions in amounts of insurance or any indemnity.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this section exceed the amount that would have been payable, if any, to the Insured Person at the date prior to your commencement of total disability.

The Insurer has the right to request proof of total disability or the continuation thereof from time to time, as the Insurer may reasonably require. Failure to provide proof satisfactory to the Insurer may result in termination of this "Waiver of Premium" section.

Conversion to an Individual Insurance Contract

In the event your coverage is terminated because:

(a) you cease to be an active Employee of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or
(b) you cease to be an eligible person under the Policy; or

(c) the period of extension of your coverage as provided in the "Extension of Coverage" section ends,

if you have not reached the age of seventy (70), you may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual accident policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual accident policy to the applicant.

However, conversion will not be possible if the Policy is terminated at the time of the application.
The benefits provided will be set out in a Specific Loss Accident Indemnity schedule available from the Insurer at the time of conversion, and the amount of insurance that may be converted will not exceed the lesser of:

(a) the amount of insurance then in effect on the date of termination; or
(b) a total aggregate amount of two hundred and fifty thousand dollars ($250,000) for all such conversions requested by the Insured Employee.

Premiums for such an individual accident policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates then in force for your attained age at the date of conversion. Premiums will be payable annually in advance and the accident policy will be issued on an annually renewable basis.

List of Companies

CAE Military Aviation Training (CMAT)

Coverage provided under this policy will extend to eligible persons of any company becoming an affiliate of, a subsidiary of, controlled by, partially or fully owned by the Policyholder during the term of this policy, provided written notice is given to the Insurer or its authorized agent, with all underwriting information pertaining to the exposure of the company, within thirty (30) days of the effective date of coverage as soons as it is reasonably possible thereafter

If any such addition to the policy constitutes a material change in the risk assumed herein, the Insurer reserves the right to adjust the premium rate accordingly.

Premium Payment

Premiums for your coverage are fully paid by you, using the means of payroll deductions.

Indemnity Payment and Beneficiaries

Indemnity payable in the event of your Loss of Life will be paid to the beneficiary or beneficiaries designated in writing by you on your most recently signed enrollment card or beneficiary designation card on file with the Policyholder, on your most recently signed

enrollment card or beneficiary designation card on file with the Policyholder, or, if there is no such beneficiary designation, such indemnity will be paid to your estate. All other indemnities payable, including those payable for your insured Spouse and/or insured Dependent Children, will be paid to you, with the exception of indemnities payable under the following sections of this booklet, for which, indemnity will be paid to the person who actually incurred the expenses giving rise to the indemnity:

- Repatriation Benefit
- Education Benefit
- Day-Care Benefit
- Workplace Modification and Accommodation Benefit
- Occupational Training Benefit
- Family Transportation Benefit
- Identification Benefit
- Home Alteration and/or Vehicle Modification Benefit

Aggregate Limit of Indemnity

The Insurer's aggregate limit of indemnity for all indemnities payable as a result of any one (1) Accident is $6,000,000. In the event said limit of indemnity for any one (1) Accident is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person will be in the proportion that the limit of indemnity for any one (1) Accident bears to the total amount of indemnity that would have been payable, not taking into consideration such limit of indemnity.

This section only applies to indemnities payable under the following sections of this booklet:

- Specific Loss Accident Indemnity
- Permanent Total Disability Indemnity
- Brain Damage Benefit

Exclusions

No benefit will be paid for any loss, fatal or non-fatal, caused or contributed to by:

a) self-inflicted injuries, suicide or attempted suicide, whether the Insured Person was sane or insane;
b) war whether declared or undeclared, and whether or not the Insured Person was actually participating therein;
c) civil commotion, riot, insurrection, armed conflict if the Insured Person was participating therein;
d) the Insured Person's service, whether as a combatant or non-combatant, in the armed forces of any country;

e) the Insured Person riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section of this booklet entitled "Aircraft Coverage";
f) medical treatment or surgery on the Insured Person, except if the medical treatment or surgery was needed because of an Accident.

Exclusions pertaining to War Risk

If an Insured Person sustains an Injury while on a trip made on the business of the Policyholder, the exclusion b) above is replaced by the following:

b) war whether declared or undeclared, in Canada and/or in the United States of America, and whether or not the Insured Person was actually participating therein;

Such trip shall be deemed to have commenced when the Insured Person leaves his/her residence or place of regular employment for the purpose of going on such trip, whichever last occurs, and shall continue until such time as he/she returns to his/her residence or place of regular employment, whichever first occurs.

IN THE EVENT OF A CLAIM

Notice of Claim

Written notice of Injury on which claim is based must be given to the Insurer within thirty (30) days after the date of the Accident resulting in such Injury.

Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled to the indemnity under the Policy, as the case may be, to the Insurer at 1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose loss is the basis of such notice.

Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Accident.

Claim Forms

The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the Insurer’s receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to the Insurer within ninety (90) days after the date of Accident resulting in such loss. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Accident.

Physical Examination and Autopsy

The Insurer will have the right and opportunity to examine, at its own expense, the person of the Insured Person whose loss is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims

All indemnities provided in the Policy for loss will be paid after customary proof of loss satisfactory to the Insurer has been given in accordance with the requirements of the Policy. With respect to Insured Persons of the Policyholder for whom premium is paid in Canadian funds, all moneys payable under the Policy are payable in the lawful money of Canada. With respect to Insured Persons of a Policyholder who pay the premium in U.S. funds, all moneys payable under the Policy are payable in the lawful money of the United States of America.

Legal Actions

Legal action will not be taken to recover indemnities under the Policy until sixty (60) days after proof of loss has been submitted to the Insurer in accordance with the requirements of the Policy. Thereafter, the claimant must take any legal action based on the Policy within a one (1) year period [three (3) years in the province of Quebec] following submission of a proof of loss to the Insurer.

Respecting your privacy

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

You have a choice

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