Sun Life Financial

your group benefits

Teck

Highland Valley Copper hourly employees

Contract Number 100259, 150046, 150839,
PAI 9129279 and BCSC9130787
Effective October 1, 2016

The Accidental Death and Dismemberment benefit (AD&D) is insured by
Chartis Insurance Company of Canada

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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.

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, Teck Resources Limited *(Teck)*, has entered into an Administrative Services Contract with Sun Life for the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care

The contract holder self-insures the benefits listed above. This means the contract holder has the sole legal and financial liability for these benefits 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.

All other benefits are insured by Sun Life.

Eligibility

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

- you are a permanent employee.
- you are actively working for your employer at least 30 hours a week.
- you have completed the waiting period.

For the Long-Term Disability Benefit and the Optional Long-Term Disability benefit, the waiting period ends on the last day of the month in which you have completed 2 months of continuous employment.

For all other benefits, the waiting period ends on the last day of the month in which your employment began. However, if your employment began on the first day of the month, there is no waiting period.

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 dependants become eligible for coverage on the date you become eligible or the date they first become your dependant, whichever is later. You must apply for coverage for yourself in order for your

dependants to be eligible.

Who qualifies as your dependant

Your dependant must be your spouse or your child and a resident of Canada.

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 is publicly represented as your spouse, is an eligible dependant. You can only cover one spouse at a time.

Spouse does not include:

- a person divorced from you, or
- a person separated from you for 1 year or more, where such separation is pursuant to a court order or a legal separation agreement, or the parties are living separate and apart without benefit of a court order or separation agreement.

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

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependant until the age of 25 as long as the child is entirely dependent on you for financial support.

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

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

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

Enrolment

You have to enrol to receive coverage. To enrol, you must send the appropriate enrolment information to your employer. For a dependant to receive coverage, you must request dependant coverage.

If you or your dependants 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 coverage under this plan at that time.

You can apply for Optional Life and Optional Long-Term Disability benefit coverage for yourself at any time. Proof of good health will be required. Coverage will not take effect before Sun Life approves the proof of good health.

You should contact your employer to get the proper forms to complete. You may be requested to have a medical examination or provide additional medical information from your doctor.

When coverage begins

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

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

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

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

Once you have dependant coverage, any subsequent dependants will be covered automatically.

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

- change of dependants.
- change of name.
- change of beneficiary.
- change of smoking status.
- change of address.

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 Sun Life Financial Plan Member Services website at www.mysunlife.ca.
- our Sun Life Financial 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 dependant's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependant is no longer an eligible dependant.
- the date the dependant child under age 21 starts working full time.
- the date the spouse is divorced from you.

- the date the spouse is separated from you for 1 year or more, where such separation is pursuant to a court order or a legal separation agreement, or the parties are living separate and apart without benefit of a court order or separation agreement.

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

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

- the date the person would no longer be considered your dependant if you were still alive.
- the last day of the third month following the month in which you die.
- the date the benefit provision under which the dependant is covered terminates.

Replacement coverage

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

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

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

Making claims

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

There are time limits for making claims. These limits are discussed in

the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

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

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

Legal actions 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 dependants 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 dependant.

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 dependants 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.

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.

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

Extended Health Care
(Medicare Supplement)

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.

In this section, *you* means the employee and all dependants 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. *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.

The benefit year is from January 1 to December 31.

Deductible

The deductible is the portion of claims that you are responsible for paying.

The deductible is $25 each benefit year for each person up to a maximum of $25 per family.

After the deductible has been paid, claims will be paid up to the

percentage of coverage under this plan.

If 2 or more members of your family suffer injuries in the same accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.

If all or part of the deductible is satisfied within the last 3 months of the benefit year, your deductible for the next benefit year will be reduced by this amount.

Reimbursement level

For all eligible expenses, the reimbursement levels are described below.

However, for *Prescription drugs*, *Hospital expenses in your province*, *Medical services and equipment* and *Paramedical services* combined, the reimbursement levels described below apply to the first $1,000 of paid claims per person per benefit year. Thereafter, any eligible expenses in excess of $1,000 of paid claims per person per benefit year, are paid at 100%.

Lifetime maximum benefit

Under Extended Health Care, the maximum amount we will pay for any person is $100,000. This maximum includes expenses incurred for emergency services outside Canada.

The maximum may be reinstated following each two benefit year period of continuous coverage. If the maximum has been paid for any one illness or injury in any two benefit year period, reinstatement will only be considered when Sun Life receives and approves evidence of the person's complete recovery and return to good health.

Prescription drugs

After you pay the deductible, we will cover 80% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- compounded preparations, provided that the principal active

ingredient is an eligible expense and has a DIN.

- oral contraceptives for medical reasons.
- injectable drugs and vitamins including vitamin B12 injections for pernicious anemia.
- diabetic supplies.
- anti-obesity drugs.
- varicose vein injections.

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatment.
- the cost of giving injections, serums and vaccines.
- vaccines.
- proteins and food or dietary supplements.
- contraceptives including oral contraceptives, except as otherwise provided under the list of eligible expenses above.
- hair growth stimulants.
- products to help you quit smoking.
- drugs for the treatment of infertility.
- 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.

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.

Medical services and equipment

We will cover 80% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a licensed dentist do not require a doctor's order).

- 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. There is a limit of 720 hours per person per benefit year.

- transportation in a licensed ambulance in the province where you live, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Services of an attendant are also covered.

- transportation in a licensed air ambulance in the province where you live, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Services of an attendant are also covered.

- aerochambers.

- colostomy, ileostomy/ostomey supplies.

- 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 be received 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 treatment is received. The guide must be the current guide at the time that treatment is received.

- wigs required as a result of an illness, up to a lifetime maximum of $500 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 which is comparable to the equipment rented or purchased, 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. Wheelchair repairs and seat cushions are also covered.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery.
- surgical brassieres required as a result of surgery, up to a maximum of $150 per person in a benefit year.
- artificial limbs and eyes. For myoelectric limbs, eligible expenses are limited to the cost of a standard prosthesis.
- stump socks, up to a maximum of $200 per person in a benefit year.
- pressure gradient hose, with a compression of 30 mm Hg or higher. The maximum amount payable is $250 per person in a benefit year.
- custom-made orthotic inserts for shoes, and custom-made orthopaedic shoes or modifications to orthopaedic shoes when

prescribed by a doctor, chiropractor, podiatrist or chiropodist up to a combined maximum of $200 in a benefit year for a person under age 19 or $400 per benefit year for any other person. Arch supports are not covered. Shoes as part of the brace and repairs are also included in this maximum. We will not pay for Arch supports.

- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per person over a period of 5 benefit years. Batteries, recharging devices, accessories and repairs are also included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- insulin pumps.
- cardiac screeners.
- humidifiers and air cleaners for CPAP (continuous positive airway pressure) machines.
- cochlear implants and speech processors, when prescribed for profound deafness, up to a maximum of $4,000 per person over a period of 5 benefit years. There must be at least a 3 year warrantee on the device.

Predetermination

You must send us an estimate before you obtain any Medical services and equipment that will cost more than $3,000. This way you will know how much of the cost you will be responsible for before you incur the expense.

Paramedical services

We will cover 80% of the costs after you pay the deductible, up to a combined maximum of $1,200 per person per benefit year for all paramedical specialists listed below:

- licensed psychologists.
- licensed clinical counsellors who are active members of a provincial association which is approved by Sun Life.
- licensed, certified or registered massage practitioners.
- licensed speech therapists.
- licensed physiotherapists.
- licensed naturopaths.
- licensed acupuncturists.
- licensed chiropractors, including a maximum of one x-ray examination each benefit year.
- licensed podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year.

Hospital expenses in your province

We will cover 80% of the costs after you pay the deductible for hospital care in the province where you live.

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 a private hospital room.

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 substance abuse or beds set aside for any of these purposes in a hospital.

Chronic care hospital

After you pay the deductible, we will cover 80% of the cost of room and board in a hospital for chronic care treatment.

The maximum amount payable is the difference between the cost of a ward and a private room.

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 substance abuse.

Emergency services out of your province

We will cover emergency services while you are outside the province where you live.

We will cover the cost of:

- a semi-private hospital room, up to a maximum of 90 days per occurrence.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.
- 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. Services of an attendant are also covered.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Services of an attendant are also covered.

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 pay 100% of the cost of covered emergency services after you pay the deductible.

We will only cover emergency services obtained within 365 days 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.

Vision care

We will cover the cost of contact lenses, eyeglasses (including repairs to lenses and frames) 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.

We will cover 100% of these costs up to a maximum of $300 per person per 24 months. This maximum also includes the costs for services of an ophthalmologist or licensed optometrist, limited to 1

examination per person per 24 months.

The deductible does not apply to vision care expenses.

We will not pay for contact lenses, intraocular lenses following a cataract surgery, sunglasses, magnifying glasses, or safety glasses of any kind.

When coverage ends

Extended Health Care coverage will end when the employee retires. For more information about coverage after retirement, please contact your employer.

Coverage may also end on an earlier date, as specified in *General Information*.

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 dependant is totally disabled if prevented by illness from performing the dependant'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 or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca

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

- 365 days after the end of the benefit year you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage, whichever is earlier.

Emergency Travel Assistance

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.

In this section, *you* means the employee and all dependants 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 365 days 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. Any expenses paid will apply towards your $100,000 lifetime maximum 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 dependant 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

Allianz Global Assistance is committed to offering coverage in all countries, although political unrest or disaster situations may prevent them from offering full services. We recommend you review the Government of Canada Travel Advisory website to see if there are travel alerts issued for countries that may limit Allianz Global Assistance services during your trip.

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

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.

In this section, *you* means the employee and all dependants 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 treatment is received. Payments will be based on the current guide at the time the treatment is received.

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, we will not cover more than the fee stated in the fee guide approved by the provincial Dental Association for that specialist or, if lower, 110% of the fee for general practitioners.

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, other than a denture, a crown or a crown related 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. However, we will not alternate porcelain facings on pontics and retainers on molar teeth.

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 from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Limitation on payments

We will only pay for 1 of the following procedures in any 60 month period when the same tooth is involved:

- inlay
- onlay
- crown
- veneer

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $2,600.

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.

We will pay 100% of the eligible expenses for these procedures.

Oral examinations

2 complete examinations per lifetime.

2 recall examinations per benefit year.

2 specific examinations per benefit year.

Emergency examinations.

X-rays

1 complete series of x-rays every 36 months.

1 panorex every 60 months.

2 sets of bitewing x-rays per benefit year.

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

Professional visits

Emergency house calls.

Other services

Required consultations between two dentists, limited to 2 units of 15 minutes per benefit year.

Polishing (cleaning of teeth) and topical fluoride treatment, up to a maximum of 2 per benefit year.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers, up to a maximum of 4 per benefit year.

Pit and fissure sealants or preventive restorative resin, 1 treatment per tooth every 24 months for dependant children only.

1 diagnostic cast per benefit year.

Required consultations between the dentist and the patient, limited to 4 units of 15 minutes per benefit year.

Basic dental procedures

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

We will pay 100% of the eligible expenses for these procedures.

Fillings

Amalgam, composite, acrylic or equivalent, 5 fillings (surfaces) per tooth per 2 benefit years.

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. Stainless steel crown, 1 per tooth per 24 months.

Endodontics

Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue, 1 treatment per tooth per lifetime.

Periodontics

Treatment of disease of the gum and other supporting tissue, including management of oral manifestations and oral mucosal disorders.

Scaling and root planing

Tartar removal. Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

You are covered for up to 14 units of 15 minutes of tartar removal in a benefit year.

Occlusal adjustment

Occlusal adjustment and recontouring, you are covered for 8 units of 15 minutes per benefit year.

Periodontal appliance

Periodontal appliance, including bruxism appliance, up to a maximum of 2 appliances every 60 months.

Habit breaking appliances.

Gingival curettage Treatment of disease of the gum and other supporting tissue, including management of oral manifestations and oral mucosal disorders.

Repair Repair of bridges, dentures or crowns (other than repairs to porcelain crowns).

Recement inlays and onlays.

Rebase or reline Rebase or reline of an existing partial or complete denture, including resilient liners in a relined or rebased denture. You are covered for 2 relines or rebases per 24 months.

Oral surgery Surgery, including crown lengthening and osseous surgery, but excluding the removal of impacted teeth *(Preventive dental procedures)*and implant related surgery *(Major dental procedures).*

Anaesthesia Anaesthesia in conjunction with oral or periodontal surgery.

Restorations Inlays, onlays and crowns (other than porcelain crowns), subject to *Limitation on payments.*

Tissue conditioning You are covered for 2 tissue conditioning per arch in a 60 month period.

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

We will pay 85% of the eligible expenses for these procedures.

Major restorations Porcelain crowns, subject to *Limitation on payments.*

Repair Repair of porcelain crowns.

Post and core You are covered for 1 post and core per tooth per 60 months.

Dentures Construction and insertion of standard or precision dentures. Charges for a replacement standard or precision denture is not considered an eligible expense during the 60 months period following the

construction or insertion of a previous standard or precision denture unless:

- it is needed to replace a standard or precision 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.

Fixed bridges Construction and insertion of bridges. Charges for a replacement bridge are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge unless:

- it is needed to replace a bridge 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.

Implants Implants, including surgery charges (other than those related to grafting), subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant.

Orthodontic procedures

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

We will pay 50% of the eligible expenses for these procedures.

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.

When coverage ends

Dental Care coverage will end on the last day of the 3rd month in which the employee retires.

Coverage may also end on an earlier date, as specified in *General Information*.

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 related to the temporomandibular joint (TMJ) treatment, except otherwise indicated in the list of covered expenses.
- 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.
- 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.
- 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 or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca. The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive a claim no later than:

- 365 days after the date you incur the expenses, or
- 90 days after the end of your Dental Care coverage, whichever is earlier.

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.

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 dependant 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 dependant must be your spouse or your child and a resident of Canada as described under *Who qualifies as your dependant* in the General Information section.

If you have an absence of more than 52 consecutive weeks, you will no longer be eligible for Personal Spending Account coverage. Coverage will be reinstated upon your return to active work.

The benefit year is from January 1 to December 31.

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.

Personal Spending Account with no carry-forward feature

We must receive claims for any eligible expenses incurred in a benefit year no later than 31 days 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.*

Any credits remaining in your Personal Spending Account at the end of the benefit year will be lost.

Surviving dependant coverage

The Personal Spending Account is set up under the employee's name, and there is no continuation of coverage for dependants after the employee's death. Only eligible expenses incurred before the employee's death can be reimbursed under the employee's Personal Spending Account.

Credits

$300 at the beginning of each benefit year

Eligible expenses

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

Fitness-related services

- fitness club memberships.
- registration fees for fitness-related programs or lessons, such as aerobic classes, yoga, dance lessons and figure skating.
- sports team memberships and registration fees.
- annual memberships, such as golf.
- court fees, green fees, ski passes, lift tickets and race registrations.

- personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.

Fitness equipment

- durable equipment such as treadmills, inversion tables, exercise bikes and universal gym.
- skates, roller blades, bicycles, specialized athletic footwear, tennis racquets, golf clubs, safety helmets and specialized sports equipment.
- home workout video's and DVDs, fitness tracking monitors such as heart rate monitors, pedometers and body buggs.

Health-related services

- weight management programs (excluding food).
- smoking cessation programs.
- nutrition programs and counselling.
- stress management programs.
- services of clinical counsellors who are active members of a provincial association which is approved by Sun Life.

When coverage ends

Personal Spending Account coverage will end when the employee retires. Coverage may also end on an earlier date, as specified in *General Information*. If coverage ends because the employee is no longer actively working and the employee becomes covered again during the same benefit year, the employee's plan credits in effect on the date coverage terminated will be reinstated when the employee's coverage begins again.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

- 31 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.

Short-Term Disability
(Weekly Indemnity)

Insurer

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

General description of the coverage

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

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

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

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

When disability payments begin

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

If you become totally disabled because of an **illness**, you will be eligible for Short-Term Disability payments after 3 days of uninterrupted total disability or the first day you consult a doctor, whichever is later.

In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized as a result of an illness. To be considered hospitalized, you must have been admitted as an in-patient in a hospital or have undergone surgery under general or epidural anaesthesia.

Effective August 9, 2017 – In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized as a result of an illness. Hospitalization for elective procedures/treatments for non-disabling condition will not be considered eligible.

In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized as a result of an illness. Hospitalization for elective procedures/treatments for non-disabling condition will not be considered eligible.

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

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for at least 3 uninterrupted days in the case of illness and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer. In the case of an accident, you must be totally disabled on the date you are recalled or scheduled to return to full-time work.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability occurs again, we will consider it a continuation of your previous total disability if it occurs within:

- 2 weeks of the end of your previous disability if total disability is due to the same or related causes.
- 1 day of the end of your previous disability if total disability is due to unrelated causes.

You must be covered when the total disability reoccurs.

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

What we will pay

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

Step 1: We take 66.67% of your weekly basic earnings up to the maximum insurable earnings under the Employment Insurance Act.

Your Short-Term Disability payment will never be less than $725 per week.

Effective October 1, 2017 – Your Short-Term Disability payment will never be less than $750 per week.

Effective October 1, 2019 – Your Short-Term Disability payment will never be less than $800 per week.

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

Step 2: We subtract any income provided to you:

- under a motor vehicle insurance plan which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.
- for any disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under the Québec Parental Insurance Plan.

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

taxable), your Short-Term Disability payment is reduced by the excess.

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

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

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

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

Maternity / parental leave of absence

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

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

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

Short-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for 3 uninterrupted days or the date you are hospitalized if earlier, provided

your coverage has been continued.

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 Short-Term Disability payments plus income from other sources. However, if during any week your total income is more than 100% of your basic earnings when your disability began (less provincial and federal income taxes if your benefit is non-taxable), your Short-Term Disability payment will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled.

If you recover damages from another person

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

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

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

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

When payments end

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

- the date you are no longer totally disabled.
- the end of a maximum benefit period of 52 weeks of payment.
- the date you retire on pension.
- the date you die.

When coverage ends

Your Short-Term Disability coverage will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved rehabilitation program, if required by Sun Life.
- during which you are capable of suitable alternative employment, which is offered by and available from your employer.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence*. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.

- you are serving a prison sentence or are confined in a similar institution.

We will not pay for total disability resulting from:

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

When and how to make a claim

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

In order for you to receive benefits, we must receive these forms no later than 60 days after your total disability begins.

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

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

Long-Term Disability

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.

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 52 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 52 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

Basic coverage

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

Step 1: We take $2,000 ($2,100 ***effective October 1, 2019***) per month.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, such as the Canada Pension Plan and the Québec Pension Plan, excluding dependant benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- 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, the additional sources of income listed below and the Optional Long-Term Disability benefit, 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. Your Long-Term Disability payment will never be less than $25.

Additional sources of income provided to you:

- any amount of income provided from any employer by reason of the same or subsequent disability.
- any amount of income provided under any other group insurance, other than the amount of Optional Long Term Disability benefit, if elected, under this contract, or group prepayment plan.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.
- 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 a group plan, including any coverage resulting from your membership in an association of any kind.

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.

Optional coverage

If you have elected Optional Long-Term Disability, your Optional Long-Term Disability payment is $2,000 ($2,100 ***effective October 1,***

2019) per month.

Your Optional Long-Term Disability benefit payment will not be reduced by other sources of income.

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 52 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 Basic 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 Basic Long-Term Disability payments will be reduced by the excess.

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

Interrupted periods of disability during elimination period

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

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

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

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

Interrupted periods of disability after payments begin

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

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

If you recover damages from another person

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

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

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

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

Your responsibilities

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

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

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

When payments end

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

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

When coverage ends

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

less the elimination period of 52 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

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

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.
- bodily injury sustained while doing any act or thing pertaining to any occupation or employment for wage or profit.

When and how to make a claim

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

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

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

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

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

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

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

Life Coverage

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.

Basic Life coverage for you

Amount

Your Life benefit is $80,000.

Coverage ends

Your coverage will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount

You can apply for coverage of $80,000.

Coverage ends

Your coverage will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*. For more information about coverage after retirement, please contact your employer.

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.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death

benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

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.

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.

Retirement date

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

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.

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. Contact your employer's HR department for the available claim forms.

Accidental Death and Dismemberment Insurance (AD&D)

Basic Accidental Death and Dismemberment Insurance

Insurer ***This benefit is insured by Chartis Insurance Company of Canada.***

This benefit provides a one-time, lump sum payment if you die or are dismembered as a result of an accident, whether the accident occurs at work or not. Coverage is in effect 24 hours a day. Basic AD&D provides coverage for the employee. You may also purchase additional Optional AD&D coverage for yourself.

ELIGIBILITY

You automatically have this coverage if you are a regular full time employee.

If you receive long term disability benefits under the Company's LTD plan, premiums for Basic AD&D and Optional AD&D premiums will be waived for you until:

- You recover
- You retire
- You die
- You leave the company

whichever is **earlier**.

You may continue to be covered by this benefit if you are receiving short-term disability payments or on maternity or parental leave and also approved leave of absence.

COST

The premiums for Basic AD&D insurance are paid by the Company. There is no cost to you.

BENEFIT

The Basic AD&D benefit is coverage is $80,000

COVERAGE

If you die as result of an accident, an accidental death benefit of your Principal Sum is paid to your beneficiary.

Accidental dismemberment means the loss (severance) or loss of use of digits or limbs, or the total loss of speech, sight or hearing. The amount paid for an accidental dismemberment claim is determined by the extent of the loss.

The maximum amount payable from any one accident under the dismemberment benefit is the Principal Sum, even if more than one body part is lost. The maximum payable for paralysis is two times the Principal Sum.

TERMINATION

You are covered under this benefit until

- You retire, or
- You leave the Company before retirement

whichever is **earlier**.

CONVERSION PRIVILEGE

On the date of termination, or during the 90-day period following termination, you may covert your Basic AD&D coverage to an individual policy with the insurer. You are responsible for paying for any premiums for the new policy.

Optional Accidental Death and Dismemberment Insurance

ELIGIBILITY

You may purchase $80,000 AD&D insurance for yourself through payroll deduction if you are a regular full time employee.

If you receive LTD benefits under the Company's LTD plan, premiums for Optional AD&D for you will be waived until:

- You recover
- You retire
- You leave the Company before retirement
- You die

Whichever is **earlier**.

COST

You pay the premiums for this optional insurance through payroll deduction.

BENEFIT SCHEDULE

Benefits are paid to the designated beneficiary according to the Schedule of Loss.

PAYMENT OF BENEFITS

If you die as a result of an accident, the benefit is paid to your beneficiary, according to the Schedule of Loss.

If you are dismembered or paralysed as a result of an accident, the benefit is paid to you according to the Schedule of Loss.

TERMINATION

You have this coverage until the end of the month in which your employment with the Company ends or you retire.

SCHEDULE OF LOSS

(Basic and Optional Accidental Death & Dismemberment)

The Basic AD&D benefit for employees is $80,000. This is known as your Principal Sum.

Optional AD&D benefits benefit for employees is $80,000.

This is known as your Principal Sum.

LOSS	**BENEFIT AMOUNT** *(% of Principal Sum for Basic AD&D or % of Optional Coverage Amount)*
Death	100%
Loss of both hands or both feet	100%
Loss of entire sight of both eyes	100%
Loss of one hand and one foot	100%
Loss of one hand and the entire sight of one eye	100%
Loss of one foot and the entire sight of one eye	100%
Loss of speech and hearing in both ears	100%
Loss of one arm or one leg	80%
Loss of use of one arm or one leg	80%
Loss of one hand or one foot	75%
Loss of entire sight of one eye	75%
Loss of four fingers of one hand	66.7%

Loss of thumb and index finger of the same hand	66.7%
Loss of speech or hearing in both ears	75%
Loss of use of one hand or one foot	75%
Loss of four toes of one foot	25%
Loss of hearing in one ear	66.7%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of use of both hands	100%
Loss of use of both arms or both legs	200%
Loss of use of one arm and one leg of one side of the body	200%
Loss of use of one hand and one leg	100%
Loss of use of one arm and one leg	100%

Additional Basic and Optional AD&D Benefits

Repatriation

If you die in an accident more than 50 kilometres from your permanent place of residence, the benefit provides up to $15,000 for burial preparations and shipment of the body back to the city of residence within 365 days of the accident.

Education

Dependant Children: If you or your covered spouse die in an accident, this benefit pays up to 5% of your Principal Sum to a maximum of $5,000 per school year, to any dependant child if she or he begins or continues full time attendance at a post secondary education institute (university, private college or trade school) for up to four years.

Spouse: If you die in an accident, this benefit pays up to $15,000 for the actual cost of any professional or trade training for your spouse begun within 30 months of your death.

Day Care

If you die in an accident, a day care benefit is paid for each of your eligible dependants under 13 years of age who are currently or subsequently enrolled in an accredited day care centre within 90 days of the accidental death. The annual benefit payable for up to four consecutive years for each child is the lesser of the actual annual cost, 5% of your Principal Sum or $5,000.

In-hospital Coverage

This benefit pays a monthly benefit of 1% of the Principal Sum if you are hospitalized for more than five consecutive days, to a maximum of $2,500 per month for hospital stays up to 12 months. If you leave the hospital and must be hospitalized again due to the same accident and within three months of the accident, the successive periods are considered one period of stay.

A HOSPITAL MUST:
-be licensed (if required by the province)
-provide care and treatment for sick, ailing or injured people as in-patients
-provide 24-hour-a-day registered or graduate nursing services
-have at least one licensed physician available at all times
-provide facilities for diagnosis and major surgery
-is not primarily a clinic, nursing, rest or convalescent home or similar establishment
-is not, other than incidentally, a place for the treatment of alcohol or drug addiction

Family Transportation

If you are hospitalized more than 100 kilometres from your permanent city of residence due to an accident, this benefit pays the actual cost, to a maximum of $15,000, for direct round-trip transportation of one immediate family member to your bedside within 365 days of the accident.

Rehabilitation

An additional benefit of up to $15,000 is paid for occupational training required as a result of an accident, if the training qualifies you for new work. The training must take place within two years from the date of the accident. This benefit does not cover ordinary living, travelling or clothing expenses.

Home Alteration/Vehicle Modification

If you are required to use a wheelchair as a result of an accident, you are eligible for reimbursement up to a combined maximum of $15,000 for the one-time cost of alterations to your home to make it wheelchair accessible and habitable, and for the one-time approved cost of necessary modifications to your vehicle.Home alterations must be made by an individual recommended by a recognized organization that provides support and assistance to wheelchair users. Vehicle modifications must be approved by the vehicle licensing authorities in your province.

Seat Belt

The benefit paid as a result of a car accident is increased by 10% to a maximum $50,000 if the official police report verifies you were wearing a seatbelt properly fastened.

Comatose Benefit

If you are comatose for at least six consecutive months as a result of an accident and beginning within 90 days of the accident, this benefit pays 1% of your Principal Sum (less any other benefit paid due to the same accident under this plan) per month retroactive to the first complete day of coma, for a maximum of 100 months.

COMA

A profound state of unconsciousness from which the individual cannot be aroused, even by powerful stimulation as determined by a physician.

LIMITATIONS OF COVERAGE

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

(a) suicide or any attempt thereat by the Insured Employee while sane;

(b) self inflicted Injury or any attempt thereat by the Insured Employee while sane or insane;

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

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

(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

(f) sustained while the Insured Employee is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

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

(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Employee is:

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

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

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

(j) injury or Loss sustained while the Insured Employee is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Employee is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

(k) injury or Loss sustained while the Insured Employee is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

(l) injury or Loss sustained while the Insured Employee is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;

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

(n) natural causes.

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).

Mail your completed claim forms to:

Sun Life Assurance Company of Canada
PO BOX 11641
STN CV
Montreal QC H3C 5Z7