Sun Life Financial

your group benefits

Michaels
Where Creativity Happens®

(Classes 1, 3 and 4)

Group Policy No. 87015
Effective April 1, 2017
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Your Group Insurance Booklet

Keep in a safe place

This booklet is a valuable source of information for you and your family. It provides the information you need about the group benefits available through your employer's group plan with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies. Please keep it in a safe place. We also recommend that you familiarize yourself with this information and refer to it when making a claim for group benefits.

The Group Benefits Administration (GBTA) Team at Sun Life is there to help

The GBTA Team can:

- help you enrol in the plan
- answer any questions you may have

For administrative purposes, number 105715 will be used for the Critical Illness benefit under this plan.

Benefits and claims information at your fingertips

For more information about your group benefits or claims, please call Sun Life's GBTA Team directly at 1-866-881-0583.

We're on the Internet!

Learn more by surfing Sun Life's website. There's information about group benefits, and about Sun Life's products and services... and a whole lot more! Check us out!

Our address is:

www.sunlife.ca

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 policy.

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.

The statements in this booklet are only a summary of some of the provisions in the master policy. If you need further details on the provisions which apply to your group benefits you must refer to the master policy (available from the GBTA Team at Sun Life).

Summary of Insurance

Policy Number ***87015***

Basic Life Insurance and Accidental Death and Dismemberment Insurance

Class of Members	Benefit Formula	Maximum Benefit
All Employees	1x annual earnings	$150,000*

***Evidence of Insurability** is required for an increase in coverage of 25% or more of the existing coverage or $25,000, whichever is greater. Coverage will not take effect before Sun Life approves the evidence of insurability.

Termination of Insurance: 70th birthday or retirement, if earlier

Member Optional Life and Accidental Death and Dismemberment Insurance

Class of Members	Benefit Formula	Maximum Benefit
All Employees	units of $10,000	$250,000

Termination of Insurance: 65th birthday or retirement, if earlier

Dependant Optional Life and Accidental Death and Dismemberment Insurance

Class of Dependants	Benefit Formula	Maximum Benefit
Spouse	units of $10,000	$250,000

Termination of Insurance: the earlier of the member's 65th birthday, retirement, or the spouse's 65th birthday

Short Term Disability Insurance

Class of Members	Benefit Formula	Maximum Weekly Benefit
All Employees	66 2/3% of weekly earnings	$1,000

Weekly Disability Benefit

All references to income below and in the Short Term Disability Insurance Provision are to the gross amounts before any deductions.

Your weekly disability benefit is the lesser of 1. and 2. below:

1. the benefit formula applied to your gross weekly earnings, limited to the maximum weekly benefit, less any disability and retirement income you receive from:
    a. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
    b. an automobile insurance policy 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 automobile insurance policy, and as long as the law does not prohibit such a deduction.
    c. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.
2. 100% of your gross weekly earnings in force on the date you became totally disabled less any disability and retirement income you receive from:
    a. the Canada/Quebec Pension Plan or a similar pension plan, excluding benefits for dependent children.
    b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
    c. an automobile insurance policy 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 automobile insurance policy, and as long as the law does not prohibit such a deduction.
    d. another group insurance policy (including, after the first 17 weeks of total disability only, a policy for which you are insured because you belong to an association).
    e. a retirement income plan providing income that becomes payable after you are no longer actively at work.
    f. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.

Since your employer pays 100% of the Short Term Disability premium, your weekly disability benefit is subject to income tax.

Total Disability and Totally Disabled: mean that, during and after the qualifying period, you have a medical impairment due to injury or disease which prevents you from performing, in any setting, the essential duties of the occupation in which you participated just before the total disability started.

The medical impairment must be supported by objective medical evidence.

The availability of work for you does not affect the determination of totally disabled or total disability.

Qualifying Period

- 7 consecutive calendar days of total disability, or
- none if your total disability is due to an accidental injury caused by an unforeseen event and your total disability began within 30 calendar days of the initial injury.*

*Where Workers' Compensation, Workplace Safety and Insurance Act or other similar legislation's benefits are payable, the qualifying period will equal the Workers' Compensation, Workplace Safety and Insurance Act or similar legislation's waiting period.

Benefit Period: 17 weeks

Termination of Insurance: 65th birthday or retirement, if earlier.

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
All Employees	60% of monthly earnings	$10,000*

***Evidence of Insurability:** is required for an increase in coverage of 25% or more of the existing coverage or $500, whichever is greater. Coverage will not take effect before Sun Life approves the evidence of insurability.

Monthly Disability Benefit

All references to income below and in the Long Term Disability Insurance Provision are to the gross amounts before any deductions.

Your monthly disability benefit is the lesser of 1. and 2. below:

1. the benefit formula applied to your gross monthly earnings, limited to the maximum monthly benefit, less any disability and retirement income you receive from:
    a. the Canada/Quebec Pension Plan or a similar pension plan, excluding benefits for dependent children.
    b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
    c. an automobile insurance policy.
    d. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.
2. 85% of your net monthly earnings in force on the date you became totally disabled less any disability and retirement income you receive from:
    a. the Canada/Quebec Pension Plan or a similar pension plan, excluding benefits for dependent children.
    b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
    c. an automobile insurance policy.
    d. another group insurance policy.

e. a retirement income plan providing income that becomes payable after you are no longer actively at work.

f. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.

Since you pay 100% of the Long Term Disability premium, your monthly disability benefit is not subject to income tax.

Total Disability and Totally Disabled: mean that,

- during the qualifying period and the 24 month period immediately following it, you have a medical impairment due to injury or disease which prevents you from performing, in any setting, the essential duties of the occupation in which you participated just before the total disability started, and
- after the 24 month period, you are unable, because of the medical impairment, to perform, in any setting, the essential duties of any occupation for which you have at least the minimum qualifications.

The medical impairment must be supported by objective medical evidence.

The availability of work for you does not affect the determination of totally disabled or total disability.

Qualifying Period: 17 weeks

Benefit Period: to 65th birthday

Termination of Insurance: 65th birthday or retirement, if earlier

Member Optional Critical Illness Insurance

Class of Members	Benefit Formula
All Employees	As elected by the member, units of $10,000 The minimum benefit is $20,000 The maximum benefit is $200,000

Evidence of Insurability: required on all amounts of Optional Critical Illness Insurance, except for the first $30,000 if the request for insurance is made within 31 days of the eligibility date.

Termination of Insurance: 65th birthday, or retirement if earlier. In addition, your insurance will end on the date a Critical Illness benefit is paid for an insured condition which you sustain.

General Information

Eligibility

You are eligible, and continue to be eligible, to be a member while you meet all of the following conditions:

1. You are actively working for Michaels of Canada ULC.
2. You regularly work for Michaels of Canada ULC at least 32 hours each week.
3. You have been continuously employed by Michaels of Canada ULC at least as long as the waiting period.
4. You are a resident of Canada.

Participation is compulsory for Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability Insurance.

If you are classified as a contract employee, owner-operator, consultant, independent or if you are self-employed, you are not eligible to join the plan.

Waiting Period – 60 days

You are eligible, and continue to be eligible, for dependant insurance while you meet all of the following conditions:

1. You are a member.
2. You have at least one dependant.
3. Your dependants are residents of Canada.

Definitions

Dependant
means your spouse or a dependent child of you or your spouse. If Sun Life does not approve evidence of insurability required for a dependant, he will not be an insured dependant.

Dependent Child
means a natural, adopted or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on you for maintenance and support and who is

1. under 21 years of age,
2. under 25 years of age (26 years of age for the Extended Health Benefit for Québec residents only) and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

He, his and him
refer to both genders.

Spouse

means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship for 12 consecutive months. For members residing in Quebec, there is no minimum cohabitation period for common-law spouses if a child is born out of their relationship and they are publicly representing themselves as married.

Enrolment

To enrol for Optional Life Insurance and Optional Critical Illness Insurance, you must submit a completed enrolment form and evidence of insurability to Sun Life. You request Optional Dependant Life Insurance for your spouse by submitting a completed enrolment form and evidence of insurability for your spouse to Sun Life. You request Optional Critical Illness Insurance for your spouse and child by submitting a completed enrolment form and evidence of insurability for your spouse and child (if applicable) to Sun Life.

To enrol for all other insurance, you must submit a completed enrolment form. You request dependant insurance by submitting a completed enrolment form.

If you enrol more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability to Sun Life. If you request dependant insurance more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life.

If you have no dependant when you enrol and later acquire one, (eg. birth of first child, marriage), request dependant insurance within 31 days of acquiring the dependant.

If your new dependant is a common-law spouse, call Sun Life's GBTA Team directly at 1-866-881-0583 to find out how to enrol for dependant insurance.

For late entrants, evidence of insurability submitted to Sun Life is at your expense.

Effective Date

Your Optional Life and Optional Critical Illness Insurance is effective on the later of the date that you become eligible or the date that Sun Life approves the evidence of insurability, unless you are not actively working on that day due to disease or injury.

You become eligible for all other insurance on the latest of

- the first of the month coinciding with or following the date that you became eligible,
- the date that you enrol for insurance, or
- the date that Sun Life approves your evidence of insurability.

Optional Life Insurance and/or Optional Critical Illness Insurance for your dependant is effective on the later of the date that your dependant becomes eligible or the date that Sun Life approves your dependant's evidence of insurability.

All other dependant insurance is effective on the latest of

- the date that you become eligible for dependant insurance,
- the date that you request dependant insurance, or
- the date that Sun Life determines the insurability of all of your dependants and approves at least one dependant.

If you are absent from work on the date your insurance or your dependant insurance would be effective, then that insurance will not be effective until the date you return to active work.

Changes in Insurance

If you request an increase in the amount of your Optional Life or Optional Critical Illness Insurance, you must submit evidence of insurability to Sun Life. If you request an increase in the amount of Optional Critical Illness Insurance for your dependant, you must submit evidence of insurability for your dependant to Sun Life. If you request an increase in Dependant Optional Life Insurance, you must submit evidence of insurability for your spouse to Sun Life. The increase in the amount of insurance will be effective on the date that Sun Life approves the evidence of insurability.

An increase in your benefits, the amount of your insurance or the amount of your dependant insurance due to change in your group benefit plan's design or a change in your classification becomes effective on the date of the change, unless you are not actively working on that day due to disease or injury.

If Sun Life doesn't approve an increase in the amount of your insurance or the amount of your dependant insurance, any future increase in the maximum benefit amount will not be effective unless evidence of insurability is approved. An increase in the maximum benefit amount will be effective on the date Sun Life approves the evidence of insurability.

If, due to disease or injury, you are not actively working on the date an increase in your benefits, the amount of your insurance or the amount of your dependant insurance would be effective, the increase becomes effective on the date you return to active work. Sun Life may require evidence of insurability to establish the date that you are physically and mentally fit to return to active work. If so, the increase becomes effective on the date Sun Life establishes. If Sun Life doesn't approve the evidence of insurability required, the increase will not be effective.

For Critical Illness Insurance, to understand the impact on a person's insurance when new insured conditions are added to this plan, refer to the Critical Illness Insurance Provision.

Subrogation

Subrogation is a legal practice giving Sun Life the right to be reimbursed for benefits paid to you if you have been compensated by another person who is responsible for your loss. The intent of subrogation is to limit your benefit payments to the amount you actually lost.

Let's assume a person is responsible for your disability, and is required to compensate you for any of the loss that results from your disability. If Sun Life is paying or has paid your loss of income benefits, you may be receiving more income than you earned before you became disabled. In that case, you would reimburse Sun Life for the loss of income benefits Sun Life has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Sun Life.

Subrogation also applies to any medical and/or dental expenses you have been paid as a result of an injury caused by another person. Once you are compensated by the person who is responsible for your loss, you must reimburse Sun Life.

If subrogation applies to your claim, Sun Life will contact you to obtain the information required to proceed. You will be required to sign an undertaking to reimburse Sun Life for any amount recovered which exceeds 100% of income or expenses. Before agreeing to a settlement of your claim, Sun Life's approval must be obtained.

Comparable Coverage

If you are insured for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you may request the similar coverage offered under this plan.

If your dependant is insured for comparable coverage under another plan, you may decline the dependant coverage for the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops, you may request the similar coverage offered under this plan.

The insurance that replaces the comparable coverage is effective on the date that the comparable coverage stops.

If you request the coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability to Sun Life. If you request the dependant coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life. The insurance that replaces the comparable coverage is effective on the date that Sun Life approves the evidence of insurability. If Sun Life does not approve evidence of insurability required, the insurance will not be effective.

Termination of Insurance

Your insurance could terminate for a number of reasons. For example,

- you are no longer eligible, (i.e. you are no longer actively working),
- you reach the Termination Age,
- the provision or the policy terminates.

Member Basic and Optional Life Insurance Provision

Benefit

The amount of benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or if the beneficiary has predeceased you, payment will be made to your estate.

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.

If you become totally disabled before age 65, your Life Insurance may be continued. Premiums for the continued insurance will be waived after you have been totally disabled from the same or related causes for six continuous months or, if you are also insured for group Long Term Disability Insurance with Sun Life, when you begin receiving group Long Term Disability payments.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. The claimant must submit proof of the claim and the right to receive the benefit to Sun Life.

If you become totally disabled and are also insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim along with your claim under the group Long Term Disability Insurance to Sun Life.

If you become totally disabled and are not insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim to Sun Life after you have been totally disabled continuously for 6 months but not beyond 12 months after the date you became totally disabled.

Limitation period for Ontario:

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

Exclusions

A "pre-existing" condition is one for which you received medical attention, consultation, diagnosis or treatment, during the 12 months before you became insured. Premiums will not be waived if a disability is related to a pre-existing condition and begins within 12 months of you becoming insured. This exclusion does not apply if you, after becoming insured, have been actively working for 3 consecutive months with no absence related to the pre-existing condition.

This exclusion does not apply to you if you were insured for similar coverage under a previous policy issued to this group, if the previous policy was replaced by this provision within 31 days of its termination.

No benefit is payable for any amount of Optional Life Insurance that has been in force for less than 2 years if death is due to suicide, regardless of whether you have a mental illness or intend or understand the consequences of your actions.

At Termination

If your Life Insurance ends for any reason other than your request, you may apply to convert the group Life Insurance to an individual Life policy with Sun Life without providing evidence of insurability.

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

There are a number of rules and conditions in the group policy that apply to converting this insurance, including the maximum amount that can be converted. Please call Sun Life's GBTA Team directly at 1-866-881-0583 for details.

Dependant Optional Life Insurance Provision

Benefit

The amount of benefit will be paid to you upon the death of your insured dependant.

For Spousal Optional Life Insurance, if you have appointed a beneficiary, the amount of benefit will be paid to the beneficiary upon the death of your insured spouse.

If you become totally disabled, your Dependant Life Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Claims

A claim must be received by Sun Life within 6 years of the date of death. You must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

Exclusion

No benefit is payable for any amount of Dependant Optional Life Insurance that has been in force for less than 2 years if death is due to suicide, regardless of whether your insured dependant has a mental illness or intends or understands the consequences of their actions.

At Termination

If Dependant Life Insurance for your spouse terminates due to the termination of your Member Life Insurance, your spouse may convert the amount of the dependant insurance terminated to an individual policy on his life.

Your spouse must apply and pay the premium to Sun Life within 31 days after termination of insurance.

The conditions that apply to the Conversion Privilege for the member's insurance will apply to the Conversion Privilege for the dependant insurance.

If your Dependant Life Insurance terminates and the dependant dies within 31 days after termination of insurance, we will pay you the amount of insurance which could have been converted to an individual policy on the dependant life’s through the Conversion Privilege of this provision, or the amount stipulated in any applicable legislation, if greater.

Member Basic and Optional Accidental Death and Dismemberment Insurance Provision

Benefit

The amount of death benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or, if the beneficiary has predeceased you, we will pay your estate. The amount of dismemberment benefit will be paid to you.

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

If a claim is submitted for Repatriation, we will pay your estate. If a claim is submitted for Occupational Training for Spouse, we will pay your spouse. If a claim is submitted for Education Benefit for Child, we will pay your dependent child.

Depending on the loss suffered by you, the amount of benefit is limited to the percentage shown in the Schedule of Losses.

Schedule of Losses

Loss of Life	100%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%
Loss of Both Hands, Both Feet or Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Speech and Hearing	100%
Loss of Use of Both Hands or Both Feet	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand, One Foot or Sight of One Eye	67%
Loss of Use of One Hand or One Foot	67%
Loss of Speech or Hearing	50%

Loss of Hearing in One Ear	50%
Loss of Thumb and Index Finger of One Hand	33%
Loss of Four Fingers of One Hand	33%
Loss of All Toes of One Foot	25%

If you suffer more than one of the losses listed above as a result of one accident, Sun Life will pay the amount of benefit for only one loss. That loss will be the highest of the losses suffered by you.

When proof is received by Sun Life that you have suffered any of the losses due directly to bodily injury caused solely by an accident, the amount of benefit will be paid, provided all of the following conditions are met:

- The accident must occur while you are insured under this provision.
- The loss must occur within 365 days of the date of the accident.

If you become totally disabled, your Accidental Death and Dismemberment Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Repatriation

If you suffer loss of life, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, for the preparation and transportation of your body from the place of the accident to your place of permanent residence.

The accidental death must occur at a distance of 150 kilometres or more from your place of permanent residence.

Rehabilitation

If you suffer any of the losses, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, to train you for active employment in an occupation for which you would not have engaged except for those injuries.

The expenses must be incurred within 2 years of the date of the accident.

No payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

Occupational Training for Spouse

If you suffer loss of life, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, to enrol your spouse in an accredited occupational training program to qualify him for active employment in an occupation for which he would not otherwise have sufficient qualifications.

The expenses must be incurred within 3 years of the date of the accident.

No payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

Education Benefit for Dependent Child

If you suffer loss of life, we will pay the reasonable and customary tuition expenses to enrol your dependent child as a full-time student at a post-secondary institution provided

1. your dependent child is enrolled as a full-time student at a post-secondary institution at the time of the accident, or
2. your dependent child is a student at the secondary school level and, within 365 days of the date of the accident, he enrols as a full-time student at a post-secondary institution.

The maximum amount of benefit payable for each year that your dependent child is enrolled as a full-time student at a post-secondary institution will be the lesser of:

1. 5% of your amount of benefit, or
2. $5,000.

The amount of benefit will be paid each year, up to 4 consecutive years, after we receive proof that your dependent child is enrolled as a full-time student at a post-secondary institution.

No payment will be made for:

1. tuition expenses incurred before the date of the accident.
2. room or board or other ordinary living, travelling, or clothing expenses.

A post-secondary institution includes any accredited university, colleges d'enseignement general et professionnel, trade school, community college, or private college that provides an education above the secondary school level.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. A claim for a loss must be received by Sun Life within 3 months of the date of the loss. All other claims must be received by Sun Life within 3 months of the date that the expense is incurred. The claimant must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for a loss directly or indirectly due to

1. suicide or self-inflicted injuries, regardless of whether you have a mental illness or intend or understand the consequences of your actions,
2. disease,
3. civil disorder or war, whether or not war was declared,

4. full-time service in the armed forces of any country,
5. injuries received while riding in, or on, or boarding or alighting from an aircraft if, when the injuries were received,
    a. you were operating, learning to operate or serving as a member of a crew of any aircraft, or
    b. the aircraft was being used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Dependant Optional Accidental Death and Dismemberment Insurance Provision

Benefit

The amount of benefit will be paid to you.

Depending on the loss suffered by your insured dependant, the amount of benefit is limited to the percentage shown in the Schedule of Losses.

Schedule of Losses

Loss of Life	100%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%
Loss of Both Hands, Both Feet or Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Speech and Hearing	100%
Loss of Use of Both Hands or Both Feet	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand, One Foot or Sight of One Eye	67%
Loss of Use of One Hand or One Foot	67%
Loss of Speech or Hearing	50%
Loss of Hearing in One Ear	50%
Loss of Thumb and Index Finger of One Hand	33%
Loss of Four Fingers of One Hand	33%
Loss of All Toes of One Foot	25%

If your insured dependant suffers more than one of the losses listed above as a result of one accident, Sun Life will pay the amount of benefit for only one loss. That loss will be the highest of the losses suffered by your insured dependant.

When proof is received by Sun Life that your insured dependant has suffered any of the losses due directly to bodily injury caused solely by an accident, the amount of benefit will be paid, provided all of the following conditions are met:

- The accident must occur while your dependant is insured under this provision.
- The loss must occur within 365 days of the date of the accident.

If you become totally disabled, your Dependant Optional Accidental Death and Dismemberment Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Repatriation

If your dependant suffers loss of life, Sun Life will pay the reasonable and customary expenses, limited to a maximum of $10,000, for the preparation and transportation of your dependant's body from the place of the accident to his place of permanent residence.

The accidental death must occur at a distance of 150 kilometres or more from your dependant's place of permanent residence.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. A claim for a loss must be received by Sun Life within 3 months of the date of the loss. All other claims must be received by Sun Life within 3 months of the date that the expense is incurred. The claimant must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for a loss directly or indirectly due to

1. suicide or self-inflicted injuries, regardless of whether your insured dependant has a mental illness or intends or understands the consequences of their actions,
2. disease,
3. civil disorder or war, whether or not war was declared,
4. full-time service in the armed forces of any country,

5. injuries received while riding in, or on, or boarding or alighting from an aircraft if, when the injuries were received,
   a. your insured dependant was operating, learning to operate or serving as a member of a crew of any aircraft, or
   b. the aircraft was being used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Short Term Disability Insurance Provision

Qualifying for Weekly Disability Benefits

You qualify for benefits when Sun Life receives proof that:

1. you are absent from active work because you are totally disabled,
2. you are totally disabled for as long as the qualifying period, and
3. you are under the active and continuous care of a physician whom Sun Life considers to be appropriate to your total disability and you are following the treatment prescribed by that physician.

Your Weekly Disability Benefit

Your weekly disability benefit is calculated as shown on the Summary of Insurance at the front of this booklet.

Income to which you are entitled under a government plan will reduce your weekly disability benefit unless Sun Life receives proof that the initial application and an appeal, or a later re-application required by Sun Life, have been declined.

Increases in the disability income payable under a government plan may occur because of an automatic adjustment in the cost of living. These increases will not further reduce your weekly disability benefit.

The total income you receive from all sources will not be less than your weekly disability benefit.

Your weekly disability benefit will not be reduced by any disability and retirement income you receive from the following sources:

1. a policy which is solely an individual disability income policy.
2. a disability attachment to an individual life insurance policy.
3. a retirement income plan providing income that becomes payable before you become totally disabled.

Rehabilitation

If your total disability prevents you from returning to work, Sun Life may be able to assist you by providing a rehabilitation program that will help you return to the workforce. A rehabilitation program is limited to one or more of the following:

1. assessment,
2. counselling,
3. vocational retraining or an educational program,
4. trial work, part-time or modified work.

If, after qualifying for benefits, you are receiving income from an approved rehabilitation program, your weekly disability benefit will be reduced by 50% of that income. Your weekly disability benefit is further

reduced so that the total income from all sources does not exceed 100% of your gross weekly earnings in force on the date you became totally disabled.

Example:

> Assume you are earning $500/week and have a 66 2/3% STD benefit ($333.50). Rehabilitation income from your employer is $200/week. There is no income from other sources.

Rehabilitation Income + (Weekly Disability Benefit - 50% of Rehabilitation Income)
= $200 + ($333.50 - {50% of $200})
= $200 + $233.50
= $433.50

Since the benefit ($433.50/week) does not exceed your pre-disability weekly earnings ($500/week), there will be no reductions due to the 100% all source maximum.

If you are participating in a rehabilitation program approved by Sun Life, you continue to be considered totally disabled.

Payment of Weekly Disability Benefit

The weekly disability benefit will be paid to you when proof is received by Sun Life that you are absent from active work because you are totally disabled. Benefits are paid in arrears and will begin after you are eligible to receive them. You will receive one-seventh of the weekly disability benefit for each full day you are totally disabled following the qualifying period.

If you are absent from active work for more than half of your first day of total disability, the absence is considered one day of total disability.

Benefits are payable from the latest of

- the end of the qualifying period,
- the date you are no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan, or
- the date you are no longer entitled to receive severance pay, payments in lieu of severance pay and damages, or settlements for wrongful dismissal.

Your weekly disability benefit is payable concurrently with any disability benefit you are entitled to receive under the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.

Claims

A claim must be received by Sun Life within 3 months after the date you became totally disabled.

If you are totally disabled due to a work-related injury, a claim for the weekly disability benefit must be submitted to Sun Life at the same time a claim is submitted to the Workers' Compensation Board, Workplace Safety and Insurance Board or other similar board.

There is a time limit for appealing Sun Life's decision to decline or terminate a claim. An appeal must be made within 3 months of such a decision and must be accompanied by new objective medical evidence.

Limitation period for Ontario:

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

At Termination

If the Short Term Disability provision terminates while you are totally disabled, you will continue to be eligible for this benefit as if it were still in force.

Exclusions and Limitations

No benefit is payable for a total disability due to or related to

- intentionally self-inflicted injuries,
- civil disorder or war, whether or not war was declared.

No benefit is payable during any leave of absence mutually agreed upon by you and your employer, unless the law requires coverage for the health related portion of a maternity leave. A maternity leave of absence will begin on the earlier of the agreed leave date or the date of birth of the child.

No benefit is payable for loss of income due to elective cosmetic or experimental surgery unless the surgery or treatment is for accidental injuries or unless the surgery is medically necessary as determined by the provincial health care plan in the province where you reside.

Long Term Disability Insurance Provision

Qualifying for Monthly Disability Benefits

You qualify for benefits when Sun Life receives proof that:

1. you are absent from active work because you are totally disabled,
2. you are totally disabled for as long as the qualifying period, and
3. you are under the active and continuous care of a physician whom Sun Life considers to be appropriate to your total disability and you are following the treatment prescribed by that physician.

Your Monthly Disability Benefit

Your monthly disability benefit is calculated as shown on the Summary of Insurance at the front of this booklet.

Income to which you are entitled under a government plan will reduce your monthly disability benefit unless Sun Life receives proof that the initial application and an appeal, or a later re-application required by Sun Life, have been declined.

Increases in the disability income payable under a government plan may occur because of an automatic adjustment in the cost of living. These increases will not further reduce your monthly disability benefit.

The total income you receive from all sources will not be less than your monthly disability benefit.

Your monthly disability benefit will not be reduced by any disability or retirement income you receive from the following sources:

1. a policy which is solely an individual disability income policy.
2. a disability attachment to an individual life insurance policy.
3. a retirement income plan providing income that becomes payable before you become totally disabled.

Rehabilitation

If your total disability prevents you from returning to work, Sun Life may be able to assist you by providing a rehabilitation program that will help you return to the workforce. A rehabilitation program is limited to one or more of the following:

1. assessment,
2. counselling,
3. vocational retraining or an educational program,
4. trial work, part-time or modified work.

If, after qualifying for benefits, you are receiving income from an approved rehabilitation program, your monthly disability benefit is reduced by 50% of that income. Your monthly disability benefit is further reduced so that the total income from all sources does not exceed 100% of your net monthly earnings, in force on the date you became totally disabled.

Example:

Assume you are earning $2,000/month and have a 60% LTD benefit ($1,200). Rehabilitation income from your employer is $1,000/month. There is no income from other sources.

Rehabilitation Income + (Monthly Disability Benefit - 50% of Rehabilitation Income)

= $1,000 + ($1,200 - {50% of $1,000})

= $1,000 + $700

= $1,700

Since the benefit ($1,700/month) does not exceed your pre-disability monthly earnings ($2,000/month), there will be no reductions due to the 100% all source maximum.

If you are participating in a rehabilitation program approved by Sun Life, you continue to be considered totally disabled.

Payment of Monthly Disability Benefit

The monthly disability benefit will be paid to you when proof is received by Sun Life that you are absent from active work because you are totally disabled. Benefits are paid in arrears and will begin one month after you become eligible to receive them. You will receive one-thirtieth of the monthly disability benefit for each full day you are totally disabled following the qualifying period.

Benefits are payable from the latest of

- the end of the qualifying period,
- the date you are no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan, or
- the date you are no longer entitled to receive severance pay, payments in lieu of severance pay and damages, or settlements for wrongful dismissal.

If you become totally disabled, your Long Term Disability Insurance may be continued without payment of premiums while you are eligible to receive Long Term Disability benefit payments.

Claims

A claim must be received by Sun Life within 3 months after the end of the qualifying period. The qualifying period begins on the date you become totally disabled. Proof of continuing total disability may be required as often as necessary.

If you are receiving Workers' Compensation, Workplace Safety Insurance Act or similar legislation's benefits, you must submit a claim for the monthly disability benefit.

There is a time limit for appealing Sun Life's decision to decline or terminate a claim. An appeal must be made within 3 months of such a decision and must be accompanied by new objective medical evidence.

Limitation period for Ontario:

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

At Termination

If the Long Term Disability provision terminates while you are totally disabled, you will continue to be eligible for this benefit as if it were still in force.

Exclusions and Limitations

No benefit is payable for a total disability due to or related to

- intentionally self-inflicted injuries,
- civil disorder or war, whether or not war was declared,
- a "pre-existing" condition, if you become totally disabled within 12 months of becoming insured. A "pre-existing" condition is one for which you received medical attention, consultation, diagnosis or treatment, during the 12 months before you became insured. This exclusion does not apply if
- after becoming insured, you have been actively working for 3 consecutive months with no absence related to the "pre-existing" condition, or
- you were insured for similar coverage under a previous policy issued to this group, if the previous policy was replaced by this provision within 31 days of its termination.

Optional Critical Illness Insurance Provision

Definitions

Diagnosis

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

Life support

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

Physician

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

Specialist physician

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

Surgery

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

Survival period

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

General Description of the Insurance

Critical Illness insurance provides a benefit in the amount described in the Summary of Insurance if, after the effective date of insurance, and while insurance is in force, you or your insured dependant (spouse or dependent child) have a diagnosis of an insured condition, or you or your dependant have surgery for an insured condition, subject to the survival period. Claims will be assessed based on the Critical Illness provisions in effect on the date of diagnosis or surgery.

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

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

Changes in insurance

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

Changes in the amount of insurance

If you are not actively working or a dependent is hospitalized (other than a newborn child) on the date a change occurs, refer to *Changes in Insurance* in the *General Information* section to understand the effective date of any change to the amount of Critical Illness insurance.

The *Pre-existing conditions* provision under *Exclusions and Limitations* will apply to increased amounts of insurance as described in that provision.

Other changes

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

- members who are actively working;
- dependants who are not hospitalized (other than newborn children); and
- persons already having Critical Illness insurance

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

If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of insurance for the new insured conditions. If a dependent is hospitalized when the change occurs (other than a newborn child), the change will take effect when the dependant is discharged and resumes normal activities and such date will be the dependant’s effective date of insurance for the new insured conditions.

In all instances, Sun Life will:

- apply the effective date of insurance to determine a person's eligibility for a Critical Illness benefit payment; and
- apply the effective date of insurance for the new insured conditions to any exclusions or limitations under this plan, including the *Pre-existing conditions* provision. Such exclusions and limitations will be applied to the new insured conditions even if the explicit wording of this plan provides otherwise, including where:
    - Evidence of Insurability was previously required for a person's insurance; or

- the *Child moratorium period exclusion* previously applied or the child was born or adopted later than 10 months after the date the member became insured for Child Critical Illness.

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

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

- the new plan, including insurance for any new Critical Illness conditions which were not included under the previous carrier's plan, applies to all members and dependants on the effective date of this plan, regardless of whether the member is actively working or the dependant is hospitalized on such date;
- for any new Critical Illness conditions referred to above, when applying the *Pre-existing conditions* provision or any other exclusion or limitations of this plan, the effective date of insurance is the effective date of this plan; and
- for Critical Illness conditions under this plan which were also insured under the previous carrier's plan, when applying the *Pre-existing conditions* provision or any other exclusion or limitation of this plan, the effective date of insurance is the date the person most recently became insured under the previous carrier's plan.

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

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

Insured Conditions for Members, Spouses and Children

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

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

Exclusion:

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

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

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

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

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

Exclusion:

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

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

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

Exclusions:

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date Sun Life receives enrolment information for any amount of insurance; or
- the effective date of such amount of insurance,

the insured person has any of the following:

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

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

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

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

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

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

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

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

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

Exclusions:

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

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date Sun Life receives enrolment information for any amount of insurance; or
- the effective date of such amount of insurance,

the insured person has any of the following:

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

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

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

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

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

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

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

Exclusion:

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

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

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

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

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

The insured person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and

- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period. The diagnosis of dementia must be made by a specialist physician. The insured person must survive for 30 days following the date of diagnosis.

Exclusion:

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

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

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

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

Exclusion:

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

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

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

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

Activities of daily living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;

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

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

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

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

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

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

Exclusion:

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

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

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

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

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

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

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

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

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

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

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

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

- the date Sun Life receives enrolment information for such amount of insurance; or
- the effective date of such amount of insurance.

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

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

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

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

Exclusions:

No benefit will be payable under this condition if:

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

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

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

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

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

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

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date Sun Life receives enrolment information for any amount of insurance; or
- the effective date of such amount of insurance,

the insured person has any of the following:

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

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

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

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

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

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

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

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

- acute onset of new neurological symptoms; and

- new objective neurological deficits on clinical examination,

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

Insured Conditions for Children Only

Sun Life provides insurance for any illness, disorder or surgery that is defined below.

You cannot apply for Critical Illness insurance for children until you have children who are living.

Children may be subject to either the *Child moratorium period exclusion* or the *Pre-existing conditions* provision as described below. When applicable, the *Child moratorium period exclusion* and the *Pre-existing conditions* provision apply to all insured conditions for which the child is insured.

For children:

- who are the children of you or your spouse and are born during the period beginning 90 days prior to the date you become insured for Child Critical Illness and ending 10 months after such date, the *Child moratorium period exclusion* applies.
- who are the children of you or your spouse and are born or adopted later than 10 months after the date you become insured for Child Critical Illness, neither the *Child moratorium period exclusion* or the *Pre-existing conditions* provision apply.
- other than those described above, the *Pre-existing conditions* provision applies unless Evidence of Insurability is required for the child's insurance.

Critical Illness insurance may terminate for one child but continue for your other children. In the event that you only have one child living for whom insurance ends, then your Critical Illness insurance for children terminates.

References to an insured person include children.

Cerebral Palsy means a definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements.

The diagnosis of cerebral palsy must be made by a specialist physician. The insured person must survive for 30 days following the date of diagnosis.

Congenital Heart Disease means a definite diagnosis of at least one of the insured heart conditions described below. It also means the specific conditions described below for which open heart surgery is performed to correct the condition.

Insured heart conditions:

- coarctation of the aorta,

- Ebstein's anomaly,
- Eisenmenger syndrome,
- Tetralogy of Fallot,
- transposition of the great vessels.

The diagnosis of the heart condition must be:

- made by a specialist physician; and,
- supported by cardiac imaging acceptable to Sun Life.

The insured person must survive for 30 days following the date of diagnosis.

Insured heart conditions if open heart surgery is performed (these heart conditions are insured only if open heart surgery is performed to correct at least one of them):

- aortic stenosis,
- atrial septal defect,
- discrete subvalvular aortic stenosis,
- pulmonary stenosis,
- ventricular septal defect.

Procedures not insured by this definition are:

- percutaneous atrial septal defect closure;
- trans-catheter procedures which include balloon valvuloplasty.

The diagnosis of the heart condition must be made and the surgery must be recommended and performed:

- by a specialist physician; and,
- supported by cardiac imaging acceptable to Sun Life.

The insured person must survive for 30 days following the date of surgery.

Cystic Fibrosis means a definite diagnosis of cystic fibrosis where the insured person has chronic lung disease and pancreatic insufficiency.

The diagnosis of cystic fibrosis must be made by a specialist physician. The insured person must survive for 30 days following the date of diagnosis.

Down's Syndrome means a definitive diagnosis of Down's syndrome supported by chromosomal evidence of Trisomy 21.

The diagnosis of Down's syndrome must be made by a specialist physician. The insured person must survive for 30 days following the date of diagnosis.

Muscular Dystrophy means a definite diagnosis of muscular dystrophy where the insured person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

The diagnosis of muscular dystrophy must be made by a specialist physician. The insured person must survive for 30 days following the date of diagnosis.

Type 1 Diabetes Mellitus means a definite diagnosis where the insured person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The insured person must survive for 90 days following the date of diagnosis.

Claims

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

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

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

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

Limitation period for Ontario:

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

Exclusions and Limitations

Sun Life will not pay for any illness, disorder or surgery not specifically defined under Insured Conditions.

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

- intentionally self-inflicted injuries or attempted suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol.

Child moratorium period exclusion – Any child of you or your spouse will be excluded from Critical Illness insurance if:

- that child was born within the 90 day period prior to the date you obtain Child Critical Illness insurance; or,
- that child is born on or within 10 months after the date you obtain Critical Illness insurance for existing children,

and, before or within 90 days after that child's birth:

- that child is diagnosed with any insured condition; or,
- that child has any signs, symptoms or investigations that lead to a diagnosis of an insured condition within 5 years of the child's birth.

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

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

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

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

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

This exclusion does not apply where the *Child moratorium period exclusion* applies or to any child of the member or the member’s spouse who is born or adopted later than 10 months after the date the member becomes insured for Child Critical Illness.

Portability

If your Critical Illness insurance ends for any reason other than your request, you may apply to transfer the group Critical Illness insurance to another critical illness policy without providing Evidence of Insurability.

If your insured spouse's Critical Illness insurance ends for any reason other than your request, your spouse may apply to transfer the group Critical Illness insurance to another critical illness policy without providing Evidence of Insurability.

At the time that you and/or your insured spouse apply to transfer group Critical Illness insurance to another critical illness policy, you or your spouse may also apply to transfer the group Critical Illness insurance for any insured children. Sun Life will not require the child's Evidence of Insurability. However, if either you or your spouse maintain insurance under this plan, the Critical Illness insurance for the child cannot be transferred.

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

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

Best Doctors

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

If you or your spouse is insured for Critical Illness, you, your spouse and your dependent children have access to Best Doctors. If only your dependent children are insured for Critical Illness, no access to Best Doctors is provided.

Best Doctors offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition, even if it is not an insured condition under this Critical Illness benefit. To learn more about Best Doctors services, or to use these services, please call Best Doctors at 1-877-419-BEST (2378).

Liability and responsibility of Sun Life

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

Sun Life cannot guarantee the availability of Best Doctors services.

Extended Health Insurance Provision

Benefit

To qualify for the Extended Health coverage, you or your dependant must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

You will be reimbursed when you submit proof to Sun Life that you or your insured dependant has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. The total amount of eligible expenses you submit to Sun Life as a claim will be adjusted as follows:

1. the eligible expense maximums are applied,
2. the deductible, which must be satisfied each calendar year, is subtracted, and
3. the reimbursement percentage is applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent 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.

Claims

A claim must be received by Sun Life within 18 months of the date that the expense is incurred. However, if your coverage terminates, any claim must be received by Sun Life no later than 90 days following the end of the coverage.

For the assessment of a claim, itemized bills, attending physician statements or other necessary information are required.

If your physician is recommending medical treatment that is expected to cost more than $1,000, you should request pre-authorization to ensure that the expenses are covered.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,

- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage
- expenses for 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*,
- expenses for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

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

At Termination

If, on the date of termination of your insurance,

- you have a medically determinable physical or mental impairment due to injury or disease which prevents you from performing the regular duties of the occupation in which you participated just before the impairment started, regardless of the availability of work for you, or
- your insured dependant has a medically determinable physical or mental impairment due to injury or disease, is receiving treatment from a physician and is confined to a hospital or his home,

benefits will be payable for eligible expenses related to the impairment provided they are incurred within 90 days of the date of termination and this provision continues in force.

If you die, your surviving spouse under the plan will be offered the opportunity to enrol for Extended Health Insurance Benefits for himself and your surviving dependent children.

If you die, your insured dependant's Extended Health Insurance Benefits will be continued for 3 months without payment of premiums as long as the Extended Health Insurance provision remains in force. They will be contacted by the GBTA team.

My Health CHOICE Coverage

If your coverage under this plan terminates because your employment has ended, you may purchase Sun Life's My Health CHOICE coverage. This coverage is different from your group plan.

To be eligible for My Health CHOICE coverage, you must:

- apply for My Health CHOICE coverage within 60 days after the termination of your coverage,
- be under age 75 on the date you apply, and
- be a resident of Canada and be covered under the provincial health plan.

My Health CHOICE coverage may also include Dental coverage if you were covered for both Extended Health Care and Dental Care benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependents if those family members were covered under your group plan. Your spouse must be under age 75 on the date you apply for this coverage.

From time to time, Sun Life may review the eligibility requirements and, on the date you apply for My Health CHOICE coverage, they may be different from those listed in this booklet.

To apply for My Health CHOICE or if you have any questions, please call our Customer Solutions Centre at 1-877-893-9893.

Extended Health – Pay Direct Drug Benefit

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs and supplies have been evaluated based on their clinical and cost effectiveness and then classified under the Reformulary Group's formulary, the Reformulary, into 3 tiers accordingly:

1. **Tier 1** – Selected best value drugs and supplies. The majority of covered drugs and supplies are classified in Tier 1.
2. **Tier 2** – Selected drugs and supplies, where better value alternatives exist under Tier 1.
3. **Tier 3** – Selected drugs and supplies, where better value alternatives exist under Tier 1 or Tier 2.

Drugs and supplies are reviewed on a regular basis and classified in one of the above tiers. There are certain drugs and supplies that have not yet been classified. Until such time, they will be paid at 90% reimbursement level.

Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible and be approved under *Drug evaluation*.

1. selected drugs and supplies listed in the Reformulary Group's formulary, the *Reformulary*.
2. drugs which legally require a prescription.
3. life-sustaining drugs which may not legally require a prescription.
4. injectible drugs and vitamins.
5. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
6. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
7. vaccines.
8. colostomy supplies.
9. varicose vein injections.
10. products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $500 for each person.
11. drugs for the treatment of infertility.

A person who is prescribed a drug or supply that is not eligible under Tier 1 can speak with the attending physician as there may be another drug or supply that is payable at Tier 1 reimbursement level. If there is a medical reason why a person cannot take a Tier 1 drug or supply, the Tier 2 or Tier 3 drug or supply may be covered at Tier 1 reimbursement level, provided that the person and the attending physician complete and submit an exception form and that the information meets Sun Life's medical criteria. If the information provided meets Sun Life's medical criteria, the person will be covered for these drugs and supplies at Tier 1

reimbursement level. If not, the person will be covered for these drugs and supplies at the tier reimbursement level under which they are classified.

Drugs and supplies are reviewed on a regular basis and may change tiers. Refer to Sun Life's website at *www.mysunlife.ca* for the tier reimbursement level for particular drugs and supplies.

Drug evaluation

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

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

Drug expenses are eligible for reimbursement only if incurred on or after the date of Sun Life's approval.

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

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

Pharmaceutical services (rendered by pharmacists) – For members and insured dependants who live in Québec, Sun Life will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

Régie de l'assurance-maladie du Québec (RAMQ) Formulary Drugs for Québec Residents

In addition to the above eligible expenses, this benefit includes all drugs covered by Québec's basic drug formulary, as established by the RAMQ. The minimum reimbursement percentage required by provincial legislation is applied up to the annual out-of-pocket maximum, as specified by law. This formulary is reviewed on a regular basis and is subject to change as new drugs and drug products are introduced.

For Québec residents, any maximums included in this benefit do not apply to eligible drugs covered by the RAMQ formulary.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your insured dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. any drug charge a person age 65 or over has to pay under a provincial drug plan,
3. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
4. expenses for drugs which, in Sun Life's opinion, are experimental,
5. expenses for dietary supplements, vitamins and infant foods,
6. expenses for contraceptives (other than oral),
7. expenses for drugs which are used for cosmetic purposes,
8. expenses for drugs used for the treatment of sexual dysfunction,
9. expenses for drugs used for the treatment of obesity,
10. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
11. expenses for 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,
12. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion,
13. expenses for drugs and supplies, the high costs of which are not supported by demonstrated superior clinical effectiveness relative to cost of one or more alternatives available under the plan, as determined by Reformulary Group, and
14. expenses for drugs and supplies due to significant safety concerns documented by Health Canada or another relevant regulatory body.

Drug Substitution

For members and covered dependants who live in Québec, for drugs listed in the Régie de l’assurance-maladie du Québec (RAMQ) drug formulary, if the prescribed drug has a lower priced equivalent drug, charges in excess of the lowest priced equivalent drug may not be considered when calculating the reimbursement, unless Sun Life specifically approved the charges for the higher priced drug. To assess the medical necessity of a higher priced drug, Sun Life will require the covered person and the attending doctor to complete and submit an exception form. Charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless Sun Life specifically approved the charges for the higher priced drug.

Special authorization program

The special authorization (SA) program applies to a limited number of drugs and supplies and prior approval is required for coverage under the program. If a drug or supply that is included in the SA program is prescribed, both the person and the attending physician must complete a special authorization form. If the information provided meets Sun Life's medical criteria, the person will be covered for these drugs and supplies at Tier 1 reimbursement level. If not, the claim will be declined.

Extended Health – Vision Benefit

Definitions

Ophthalmologist
means a person licensed to practise ophthalmology.

Optometrist
means a member of the Canadian Association of Optometrists or of a provincial association associated with it.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense:

1. eye examinations by an ophthalmologist or optometrist limited to one examination in a 24 month period (12 month period for an insured dependant under age 18).
2. eyeglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Insurance for eligible expenses incurred during a 24 month period for you and for each insured dependant.
3. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to a lifetime maximum of $200 for the non-surgical treatment of keratoconus for you and for each insured dependant and a maximum of $200 for expenses incurred within six months of each surgical procedure.

Exclusion

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Preferred Vision Services (PVS)

Preferred Vision Services Inc. (PVS) is a network of more than 1,000 healthcare service providers across the country. The PVS program offers discounts on the purchase of prescription eyewear, hearing aids and even laser eye surgery through preferred providers registered in the PVS network. As long as you are covered under this group benefits plan, you and your dependants are eligible for the PVS discount program.

Read more about the PVS program and how to obtain savings on your purchases in our PVS brochure. The brochure also includes a PVS card to take with you when you visit a PVS provider. A copy of the brochure is available by calling Sun Life's GBTA Team directly at 1-866-881-0583 or when you sign into our Sun Life Financial Plan Member Services website at *www.mysunlife.ca.*

New providers and services are being added to the network all the time. To find out what services are available and for the PVS locations nearest you, call the PVS information centre toll-free number 1-800-668-6444, or visit the PVS website at *www.pvs.ca*.

Extended Health – Hospital Benefit

Definitions

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the items of expense listed below:

1. accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.
2. chronic care user fees or convalescent care user fees for room and board charges in a hospital, limited to a maximum of $20 per day for 120 days per calendar year.

Exclusion

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Supplementary Health Care Benefit

Definitions

Hospital
means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant, Licensed Practical Nurse
means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or bodily injury and prescribed by a physician.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.), registered nursing assistant (R.N.A.), certified nursing assistant (C.N.A.) or licensed practical nurse (L.P.N.) when provided in the patient's home, limited to a maximum of $10,000 in a calendar year. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A., or L.P.N.
2. the services of the following practitioners, limited to a combined maximum of $750 per calendar year.
   a. a physiotherapist,
   b. a registered massage therapist,
   c. a speech language pathologist,
   d. a psychologist,
   e. a chiropractor*, including one x-ray examination per calendar year,
   f. an osteopath*, including one x-ray examination per calendar year,
   g. a naturopath*, and
   h. a podiatrist or chiropodist*, including one x-ray examination per calendar year.

   * physician's prescription not required.

The practitioner must be registered with the appropriate association or registry. Where applicable, expenses for practitioners' services eligible under a provincial health care plan will not be reimbursed until your expenses exceed the annual maximums under your provincial plan.

3. the services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 12 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident. A physician's prescription is not required.
4. licensed ground ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.
6. orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist or chiropodist, limited to a maximum of $400 in a calendar year (Employee only).
7. hearing aids and repairs to them, excluding batteries, limited to a maximum of $500 for eligible expenses incurred during a 5 year period.
8. trusses and crutches.
9. braces, provided they are not solely for athletic use.
10. artificial limbs or other prosthetic appliances.
11. oxygen.
12. diagnostic laboratory and x-ray examinations.
13. wigs and hairpieces required as a result of chemotherapy or radiation treatment, limited to a maximum lifetime amount of $75.
14. mammary prosthesis, following mastectomy. Replacements are limited to once per 2 calendar years.
15. surgical brassieres following a mastectomy, limited to a maximum of 2 surgical brassieres in a calendar year.
16. rental, or purchase at Sun Life's option, of medically necessary durable equipment that meets the patient’s basic medical needs and is approved by Sun Life, limited to a calendar year maximum of $5,000. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:
    a. wheel chairs,
    b. wheel chair repairs, limited to a lifetime maximum of $250,
    c. walkers,
    d. hospital beds,
    e. traction kits.

17. the following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence.
    a. public ward accommodation and auxiliary hospital services in a general hospital limited to, after deducting the amount payable by a government plan, a maximum of $75 a day for 60 days in a calendar year.
    b. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

    Items of expense incurred outside Canada are eligible only if they are not offered in any province in Canada.
18. ***Effective November 1, 2017*** - Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, limited to a combined maximum of $4,000 in a calendar year. You must provide Sun Life with a physician's note confirming the diagnosis.

Exclusions

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the user of a service,
5. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Out-of-Province Emergency and Travel Assistance Benefit

To be insured for this benefit, you and your insured dependant must have provincial health care coverage. Expenses for hospital/medical services and travel assistance benefits are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside your home province,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 60 days of travelling on vacation or business outside your home province. Your 60 days of coverage starts on the day you or your insured dependant departs from your home province.

Definitions

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

Emergency services
mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your insured dependant have a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Family member
means you or your insured dependant.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Relative
means your spouse, parent, child, brother or sister.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact our 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 we have the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the family member is medically stable to return to his province of residence.

Emergency Services Excluded from Coverage

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

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that we or Allianz Global Assistance, based on available medical evidence, determines that the family member can be returned to his province of residence, and he refuses to return.
4. services which are required for the same illness or injury for which the family member received emergency services, including any complications arising out of that illness or injury, if the family member had unreasonably refused or neglected to receive the recommended medical services.
5. 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.

Eligible Expenses for Hospital/Medical Services

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services, less the amount payable by a government plan:

1. public ward accommodation and auxiliary hospital services in a general hospital,
2. services of a physician,
3. economy air fare for the patient's return to his province of residence for medical treatment,
4. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation,
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

The maximum lifetime amount payable for the above Eligible Expenses is $1,000,000 for you and for each insured dependant.

Expenses that are included as Eligible Expenses under Drug, Vision, Hospital or Supplementary Health Care benefits are also eligible while you or your insured dependant is travelling outside Canada. These expenses are subject to the deductibles and reimbursement percentages listed under the appropriate benefit in the Summary of Insurance.

Eligible Expenses for Travel Assistance Benefits

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services:

1. family assistance benefits, which include reimbursement for the cost of:
    a. return transportation for insured dependent children who are under the age of 16, or who are handicapped, if they are left unattended because you or your spouse is hospitalized outside your province of residence. Sun Life will arrange the transportation of the dependent child to your home, and if necessary, an escort will be provided to accompany him. The maximum payable for the return transportation is a one-way economy fare for each dependent child.
    b. return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
    c. visit of one relative, if a family member is hospitalized for more than 7 days while travelling without a relative. This includes meals and accommodation up to a maximum of $150 per day, and round-trip economy transportation, for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of his body.
    d. meals and accommodation up to a maximum of $150 per day per family, if a trip is extended because a family member is hospitalized.

    The combined maximum amount payable for the above family assistance benefits is $5,000 for one travel emergency.
2. return of a deceased family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. The maximum amount payable for the preparation and return of the deceased is $5,000. Preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased **includes** a basic shipping container, but **excludes** expenses for burial, such as burial caskets and urns.
3. return of a vehicle. If a family member is unable to operate a vehicle (owned or rented) because he is being returned to Canada for medical treatment, Sun Life will reimburse the cost of returning this vehicle to his province of residence, or the nearest appropriate rental agency. This benefit is also payable in the event of a family member's death. The maximum amount payable for returning the vehicle is $1,000.

Travel Assistance Services

Out-of-province and around-the-world services are provided through Allianz Global Assistance, a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Allianz Global Assistance will be able to provide you and your insured dependants with the following emergency assistance services during the first 60 days of travel:

1. physician and hospital referrals,
2. on-going monitoring of medical treatment if a family member is hospitalized,
3. coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer him to another hospital that is equipped to provide the required treatment,

4. payment assistance for hospital/medical expenses,
5. legal referrals,
6. a telephone interpretation service,
7. a message service for you, your family, friends and business associates.

Emergency Payment Assistance

Eligible Hospital/Medical Expenses:

To ensure payment of these expenses,

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Sun Life Travel card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Allianz Global Assistance will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your insured dependant.
3. You will be required to sign an authorization form allowing Allianz Global Assistance to recover any amounts payable by the provincial health care plan.
4. For expenses that require a percentage paid by you, or that are not covered under this plan or the provincial health care plan, you must reimburse Sun Life for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Allianz Global Assistance and they will coordinate payments with the provincial health care plan and Sun Life.

24 Hour Helpline

If emergency assistance is needed, a 24 hour helpline is available. Multilingual coordinators at Allianz Global Assistance can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The 24 hour helpline can assist you and your insured dependant if you have lost your passport or visa, if you need to find a local legal advisor, or if you require telephone interpretation services. You can also call the helpline and leave important messages for family, friends or business associates; likewise, they can call the helpline and leave messages for you while you travel. Allianz Global Assistance will hold such messages for 15 days.

When calling the 24 hour helpline, please be ready to state your Policy No., Certificate No., ID No., and Provincial Medical Insurance Plan/Health Card Number.

Please consult the telephone numbers on your Travel card.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your insured dependant due to an emergency which occurs more than 60 days after departure from your province of residence,
2. expenses incurred on a non-emergency or referral basis,
3. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Insurance Provision.

If you are covered as a retired employee, you and your insured dependants must return to your province of residence for at least 30 consecutive days before becoming eligible for another 60 days of coverage.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries. For more information on travelling conditions and the availability of Allianz Global Assistance services in a particular country, please call the appropriate 24 hour helpline.

Neither Sun Life nor Allianz Global Assistance is responsible for the availability, quality or results of the medical treatment received by you or your insured dependant, or for the failure to obtain medical treatment.

Dental Insurance Provision

Benefit

This dental plan is a means to help you to pay for your dental treatment. The services and procedures outlined in this booklet are not a treatment plan and should not determine the treatment and care decisions you and your dentist make. Your actual needs should determine these decisions.

You will be reimbursed when you submit proof to Sun Life that you or your insured dependant has incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the deductible, which must be satisfied each calendar year, is subtracted,
2. the reimbursement percentage is applied, and
3. the maximums specified in the Summary of Insurance are applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Sun Life reserves the right to refuse any assignment of benefits under this provision.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent 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.

Claims

A claim must be received by Sun Life within 18 months of the date the expense is incurred. However, if your coverage terminates, any claim must be received by Sun Life no later than 90 days following the end of the coverage.

For the assessment of a claim, itemized bills, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other necessary information may be required.

If your dentist has recommended dental treatment that is expected to cost more than $500, or if your dentist has recommended dental treatment involving dentures, bridges or crowns, you may have your dentist prepare a pre-treatment plan that you can submit to Sun Life before you start treatment. For any other dental treatment, you can call Sun Life at 1 800 361-6212 to determine if the recommended dental treatment is eligible for payment.

Limitation period for Ontario:

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

Alternate Benefit

When deciding what will be paid for a procedure, Sun Life may take into account alternate procedures, services, courses of treatment and materials available, and may provide dental benefits based on the least

costly procedure, service, course of treatment and materials which will produce a professionally adequate result that is consistent with current, accepted standards of dental practice.

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services performed by a person who is ordinarily a resident in the patient's home or who is closely related to the patient by blood or marriage,
- expenses 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.

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with. Laboratory charges are also limited to 66 2/3% of the fee for the procedure in the Dental Fee Guide shown on the Summary of Insurance.

At Termination

If you die, your insured dependant's Dental Insurance Benefits will be continued for 3 months without payment of premiums as long as the Dental Insurance provision remains in force. They will be contacted by the GBTA team.

Dental Insurance Provision – Diagnostic/Preventive Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examination and diagnosis
   - oral examination (once every 36 months),
   - limited/recall examination (once every 6 months),
   - limited periodontal examination (once every 6 months),
   - specific oral examination (once every 12 months),
   - emergency oral examination (once every 12 months),

b. tests and laboratory examinations
   - biopsy of oral tissue,
   - pulp vitality tests,

c. radiographs
   - complete series (once every 36 months),
   - periapical,
   - bitewing (once every 12 months),
   - panoramic (once every 24 months),

d. preventative services
   - dental polishing (once every 6 months),
   - topical application of fluoride phosphate (once every 12 months),
   - pit and fissure sealants (for persons under 19 years of age),
   - interproximal discing (for children under 12 years of age),
   - recontouring of teeth for functional reasons,

e. space maintainers (for children under 18 years of age)

f. habit breaking appliances

g. drug injections

h. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses for replacement of space maintainers which have been lost, stolen or mislaid,
4. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
5. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Restorative Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examinations
   - oral examinations,

b. restoration
   - caries control,
   - trauma control,
   - amalgam (bonded amalgam fillings are paid at the non-bonded equivalent),
   - acrylic or composite resin (Primary teeth and permanent anteriors and bicuspids only; permanent molars are paid at the amalgam equivalent),
   - prefabricated restorations,

c. periodontics
   - non surgical services,
   - scaling and root planing (not exceeding 8 time units each year),

d. denture repairs (once every 36 months)

e. relining rebasing and tissue conditioning of dentures (once every 36 months)

f. surgical services
   - uncomplicated removals,
   - surgical removals and repositioning,
   - surgical excision,
   - surgical incision,
   - fractures,
   - lacerations,
   - frenectomy,
   - miscellaneous surgical services,

g. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia,
   - deep sedation,
   - conscious sedation,

h. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Orthodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense **incurred by an insured dependent child under age 21** for the treatment of malocclusion or for orthodontic treatment -

a. observation, adjustment
   - oral examination,
   - skull and facial bone survey,
   - cephalometric radiographs,
   - hand and wrist radiographs,
   - diagnostic cast,
   - surgical services,
   - observation, adjustment,
   - repairs, alterations,
   - active appliances for tooth guidance or uncomplicated tooth movement,
   - retention appliances,

b. control of oral habits
   - appliances,
   - adjustments, repairs, maintenance,

c. comprehensive treatment

d. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia,
   - deep sedation,
   - conscious sedation,

e. laboratory procedures

Exclusions

No benefit is payable for:

1. expenses for replacement of orthodontic appliances which have been lost, stolen or mislaid,
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Periodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. periodontics
   - surgical services,
   - post-surgical treatment,
   - adjunctive procedures,
   - occlusal adjustment/equilibration (not exceeding 4 time units every year),
   - appliances,
   - maintenance adjustments & repairs (once every 6 months),
   - post treatment evaluation,

b. major surgery
   - alveoloplasty,
   - enucleation of cyst,
   - dislocations,

c. x-rays
   - temporomandibular joint x-rays,

d. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia,
   - deep sedation,
   - conscious sedation,

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement of periodontal appliances which have been lost, stolen or mislaid,
3. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Denture Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. partial and complete dentures
   - complete dentures,
   - partial dentures,

b. remakes and adjustments
   - adjustment to dentures,
   - remake partial dentures,

c. examinations
   - oral examination,
   - diagnostic casts,

d. laboratory procedures

Replacement of an existing denture or bridgework with a denture, is an eligible expense if the replacement is required to replace an existing denture which was installed at least 8 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to an existing partial denture is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependant is insured under this benefit.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for initial dentures to replace a tooth or teeth missing before you or your insured dependant became insured under this benefit or to replace a tooth or teeth congenitally missing,
3. expenses for replacement dentures which have been lost, stolen or mislaid,
4. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
5. expenses for replacement of dentures and addition of teeth to existing dentures except as provided under Eligible Expenses,
6. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Bridge Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. fixed bridgework
   - bridge pontics*,
   - retainers*,
   - other prosthetic services,

b. repairs and adjustments
   - porcelain repairs,
   - repairs to bridges,

c. examinations
   - oral examination,
   - diagnostic casts,

d. laboratory procedures

Replacement of an existing denture or bridgework with bridgework is an eligible expense if the replacement is required to replace an existing denture or bridgework which was installed at least 8 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to existing bridgework is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependant is insured under this benefit.

*Coverage for bridgework involving a permanent molar(s) is limited to the cost of a full metal pontic/retainer.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for initial bridgework (including crowns and inlays forming the retainers) to replace a tooth or teeth missing before you or your insured dependant became insured under this benefit or to replace a tooth or teeth congenitally missing,
3. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
4. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
5. expenses for replacement of bridgework and addition of teeth to existing bridgework except as provided under Eligible Expenses,

6. expenses for permanent splinting,
7. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
8. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Crown Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. crowns*, onlays*
   - crowns*,
   - other restorative services,

b. repairs and adjustments
   - porcelain repairs,
   - recementing crowns,

c. examinations
   - oral examination,
   - diagnostic casts,

d. laboratory procedures

Replacement of an existing crown or onlay is an eligible expense if the replacement is required to replace an existing crown or onlay which was installed at least 8 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

*Coverage for crowns and onlays placed on permanent molars is limited to the cost of a full metal crown/onlay.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
4. expenses for replacement of crowns or onlays except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Endodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examinations
   - oral examinations,

b. endodontics
   - pulpotomy,
   - root canal therapy,
   - periapical services,
   - other endodontic procedures,
   - emergency procedures,

c. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia,
   - deep sedation,
   - conscious sedation,

d. hemisection

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

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).