Sun Life Financial

your group benefits

The Corporation of the City of Cornwall

Active Paramedic Employees of CUPE Local 5734
Billing Group 004 Classes 12, 15 and 16

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Effective August 1, 2016

The Basic Accidental Death and Dismemberment benefit is insured by Chubb Insurance Company of Canada

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General Information

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

Classes

This booklet describes the coverage for the following classes of employees:

Class 12 – Active Paramedic Employees of CUPE Local 5734

Class 15 – Surviving Dependents of employees under age 65 of Paramedics of CUPE Local 5734

Class 16 – Surviving Dependents of employees age 65 and over of Paramedics of CUPE Local 5734

About this booklet

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

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

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

The contract holder, The Corporation of the City of Cornwall, self-insures the following benefits:

- Extended Health Care

- Emergency Travel Assistance
- Dental Care

This means The Corporation of the City of Cornwall has the sole legal and financial liability for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.

Eligibility

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

- you are a permanent employee.
- you are actively working for your employer at least 20 hours a week. Temporary, seasonal and part-time employees who work less than 20 hours a week, may not join the plan.
- you have completed the waiting period.

The waiting period for your group plan is 3 months of continuous employment.

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

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law (or the former spouse if, based on a court order, the employee must provide coverage to the former spouse), or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, is an eligible dependent. You can only cover one spouse at a time.

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

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

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

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

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

Enrolment

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request dependent coverage.

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

Normally, you request coverage for yourself or your dependents within 31 days of becoming eligible for coverage. If you do not request coverage within this time limit, you will have to provide proof of good health at your own expense.

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

When coverage begins

Your coverage begins on the later of the following dates:

- the date you become eligible for coverage.
- the date your employer receives your enrolment information for coverage.
- the date Sun Life approves your proof of good health, if required.

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

A dependent's coverage begins on the later of the following dates:

- the date your coverage begins.
- the date the dependent becomes eligible for coverage.
- the date Sun Life approves the dependent's proof of good health, if required.

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

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

If you are not actively working on the date your spouse's Optional Life coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

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

Accessing your records

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

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the

application, that you provided to Sun Life as evidence of insurability.

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

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

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

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

When coverage ends

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

- the date your employment ends. For more information about coverage after retirement, please contact your employer.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

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

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to

the appropriate section of this employee benefits booklet.

Surviving dependent coverage

If you die while covered by this plan, the following coverage may continue for your dependents, without premiums:

- Basic Life – spouse only
- Extended Health Care and Dental – spouse and children

On the date the employee would have reached age 65, the following will occur:

- Basic Life and Dental – coverage terminates
- Extended Health Care – all coverage terminates with the exception of *Hospital expenses in your province*, which the spouse may elect to continue at a cost.

Coverage will also end on the earlier of the following dates:

- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

The continuation of coverage does not apply to the child's Basic Life and spouse's Optional Life coverage.

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

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

Proof of disability

From time to time, Sun Life can require that you provide us with proof

of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

Assignments

For Life benefits, no rights or interests can be assigned.
For all other benefits, we reserve the right to refuse assignments.

Definitions

Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.

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

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

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

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

Illness An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

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

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

Extended Health Care
(Medicare Supplement)

Plan administrator

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

Expenses covered under each class

The expenses contained in this section apply as follows, depending on the class you are covered under:
For Classes 12 and 15 – all expenses are covered.
For Class 16 - only *Hospital expenses in your province* are covered.

General description of the coverage

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

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *Medically necessary* means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

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

The benefit year is from January 1 to December 31.

Deductible

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

The deductible is $10 each benefit year for each person up to a maximum of $20 per family.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

For prescription drugs there is no deductible.

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

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

Prescription drugs

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

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- drugs for the treatment of infertility.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $300 for each person.
- diabetic supplies.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.

- varicose vein injections.

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

We will cover the above drugs and supplies as follows:

- 90% for drugs and supplies listed in the Ontario drug benefit plan.
- 80% for all other eligible expenses.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- vaccines.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN), unless covered under the provincial drug benefit plan.
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug substitution limit

Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.

Prior authorization program

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

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

You will be covered for these drugs if the information you and your doctor provide meets our medical criteria. If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

Other health professionals allowed to prescribe drugs

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

Hospital expenses in your province

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and a semi-private hospital room.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have

facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Chronic care hospital

We will cover 100% of the cost of room and board in a chronic care hospital.

The maximum amount payable is the difference between the cost of a ward and a semi-private room, up to a maximum of $3 per day and 120 days for treatment of an illness due to the same or related causes. The deductible does not apply to these expenses.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

Expenses out of your province

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

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

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

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you

live, subject to the reimbursement level and all conditions applicable to those expenses.

Emergency services

We will pay 100% of the cost of covered emergency services. The deductible does not apply to these expenses.

We will only cover emergency services obtained within 60 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

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

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

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

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

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

Emergency services excluded from coverage

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

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

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 80% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services. The deductible does not apply to these expenses.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and

- covered by the medicare plan in the province where you live.

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

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $3,000,000 per person or, if lower, any other applicable lifetime maximum.

Medical services and equipment

We will cover 90% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $10,000 per person per benefit year.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:

- laboratory tests.
- MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of $1,000 per person per benefit year.

- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, to a maximum of $35 per person in a benefit year.
- contact lenses or intraocular lenses following a cataract surgery, up to a lifetime maximum of $100 per person per eye.
- wigs following chemotherapy. Wigs do not require a doctor’s order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.

- artificial limbs and eyes.
- stump socks, up to a maximum of 6 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, to a maximum of 1 pair and $400 per person in a benefit year.
- custom-made orthopaedic shoes, modifications to orthopaedic shoes or prefabricated orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $500 in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist. Repairs are included.
- radiotherapy or coagulotherapy.
- oxygen.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of $700 per person.
- insulin pumps.
- diabetic supplies.

Paramedical services

We will cover 90% of the costs after you pay the deductible, up to a maximum of $20 per visit per specialty for the paramedical specialists listed below:

- licensed massage therapists.
- licensed speech therapists.
- licensed physiotherapists.

- licensed naturopaths.
- licensed osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year.
- licensed chiropractors, including a maximum of $45 per person for x-ray examinations each benefit year.
- licensed podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year. Surgery is limited to $200 per person in a benefit year.

After you pay the deductible, we will cover 90% of the costs for licensed psychologists or social workers, up to a maximum of:

- $20 per half-hour for an individual.
- $25 per half-hour for family therapy.
- $10 per hour for group therapy.
- $20 per visit for all other visits.

After you pay the deductible, we will cover 90% of the costs for visual therapy, up to a maximum of $10 per half hour visit.

Contact lenses, eyeglasses or laser eye correction surgery

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

We will cover 100% of these costs up to a maximum of $250 per person in any 24 month period.

The deductible does not apply to eyeglasses, contact lenses or laser eye correction surgery.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind.

When coverage ends

Extended Health Care coverage will end when the employee retires or reaches age 75, whichever is earlier.

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

Payments after coverage ends

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

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

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

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-

conditioning or air-purifying equipment, whirlpools and humidifiers).

- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integration with government programs

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

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

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

When and how to make a claim

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

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

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

Emergency Travel Assistance

Plan administrator

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

Expenses covered under each class

The expenses contained in this section apply to Classes 12 and 15.

General description of the coverage

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

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

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

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 60 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

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

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

Getting help

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

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

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.
- amounts paid for services or supplies not covered by this plan.
- amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a

6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

Limits on Emergency Travel Assistance coverage

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

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

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

Liability of Sun Life or Allianz Global Assistance

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

Dental Care

Plan administrator

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

Expenses covered under each class

The expenses contained in this section apply to Classes 12 and 15.

General description of the coverage

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

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

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

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives which was current one year prior to the date the eligible expenses were incurred, regardless of where the treatment is received.

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

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

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown

or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

For Major dental procedures, we will not pay more than $2,000 per person for each benefit year.

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

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $2,500.

Restriction on payments

If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum amount we will pay for all Orthodontic procedures is $300 per person for the first 3 years of coverage.

The maximum amount we will pay for all other eligible expenses is $100 per person for the first year.

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should send us a completed dental claim form that shows the

treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Preventive dental procedures

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

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

Oral examinations

1 complete examination every 24 months.

1 recall examination every 6 months for a person under age 18 or every 9 months for any other person.

Emergency or specific examinations.

X-rays

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

1 set of bitewing x-rays every 6 months for a person under age 18 or every 9 months for any other person.

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

Other services

Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 6 months for a person under age 18 or every 9 months for any other person.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 6 months for a person under age 18 or every 9 months for any other person.

Basic dental procedures

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

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

Fillings Amalgam, composite, acrylic or equivalent.

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

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

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

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

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

Major dental procedures

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

We will pay 75% of the eligible expenses for these procedures.

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

Repair Repair of bridges or dentures.

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

Prosthodontics Construction and insertion of bridges or standard dentures. Charges for a replacement bridge or replacement standard denture are not

considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

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

Orthodontic procedures

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

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

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

The following orthodontic procedures are covered:

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

When coverage ends

Dental Care coverage will end when the employee retires or reaches age 75, whichever is earlier.

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

Payments after coverage ends

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

What is not covered

We will not pay for services or supplies payable or available

(regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

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

We will not pay for:

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

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.

- participation in a criminal offence.

When and how to make a claim

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

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

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

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

Long-Term Disability

Insurer

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

Expenses covered under each class

The expenses contained in this section apply to Class 12.

General description of the coverage

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

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

For your Long-Term Disability coverage,

- during the first 24 months (this period is known as the **own occupation period)**, you will be considered totally disabled while you are continuously unable due to an illness to perform a combination of the duties of your own occupation that regularly took at least 60% of your time to complete, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you have at least the minimum qualifications and which would provide you with an income of at least 50% of your indexed monthly earnings before you became totally disabled.

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

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

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 21 weeks or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

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

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 21 weeks and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

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

Step 1: We take 75% of your monthly basic earnings up to a maximum of $6,000.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind.

- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- under the Québec Parental Insurance Plan.

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

If this amount plus the above sources of income and all the additional sources of income listed below exceeds 85% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 80% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

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

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

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

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

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

Maternity / parental leave of absence

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

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

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

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 21 weeks, provided your coverage has been continued.

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

Partial disability program

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

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

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

work week that you are now working for your employer.

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

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

Rehabilitation program

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

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

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

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

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

Interrupted periods of disability during elimination period

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

- the initial period of total disability lasts for at least 2 weeks without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

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

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

Interrupted periods of disability after payments begin

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

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

If you recover damages from another person

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

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

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

We have the right to withhold or discontinue disability income

payments if you refuse or fail to comply with any of these terms.

Your responsibilities

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

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

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

When payments end

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

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

When coverage ends

Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 21 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

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

What is not covered

We will not pay benefits for any period:

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

We do not pay benefits if your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if:

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

If your coverage ends but you are covered again under this plan, we

will use the latest date your coverage began when applying the above limitation.

We will not consider you totally disabled if your disability results from drug or alcohol abuse. However, this limitation will not apply while you are participating in a Sun Life approved treatment program or you have an organic disease which would cause total disability even if drug and alcohol abuse ended.

We will not pay benefits for total disability resulting from:

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

When and how to make a claim

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

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

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

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

In order to receive benefits, we must receive these forms no later than 6 months after the proof of claim has been requested.

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

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

Life Coverage

Insurer

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

General description of the coverage

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

Basic Life coverage for you

Amount

Your Life benefit is 1.5 times your annual basic earnings, rounded to the next higher $1,000. The maximum amount of coverage is $200,000.

Reduction

Your benefit will reduce to $12,500 when you reach age 65 or retire, whichever is earlier.

Coverage ends

Your coverage will end when you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount

You can choose coverage in units of $10,000. The maximum amount of coverage is $100,000.

Coverage ends

Your coverage will end when you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Basic Life coverage for your dependents

Amount

Your spouse’s benefit is $1,500. Your children's benefit is $1,000 per child.

Coverage ends

Coverage for your dependents will end when you retire or reach age 75, whichever is earlier. Coverage may also end on an earlier date, as

specified in *General Information*.

Basic Life coverage for your surviving spouse – class 15

Amount

Your spouse's benefit is $1,500.

Coverage ends

Coverage for your spouse will end on the date the employee would have reached age 65. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Amount

You can choose Optional Life coverage for your spouse in units of $10,000 up to a maximum of $100,000.

Coverage ends

Optional coverage for your spouse will end when you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

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

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

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

For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount 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 desire to designate a minor as your beneficiary, you may wish to designate

someone else to receive the death benefit in trust for the minor. If a trustee is not designated, applicable legislation may require that a death benefit payable to a minor be paid instead to a court, or guardian or public trustee. If you reside in Québec and have designated a minor as beneficiary, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively (and regardless of whether you reside outside or in Québec), you may wish to consider designating your estate (or your spouse's estate in the case of Optional Life coverage for your spouse) as beneficiary and provide the executor(s) with directions in your (or your spouse's) will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

Suicide

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, while sane or insane. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

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

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

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

Total disability must continue for:

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

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

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

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

Converting Life coverage

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

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

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

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

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

When and how to make a claim

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

Basic Accidental Death and Dismemberment

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

SCOPE OF INSURANCE

The Chubb Insurance Company of Canada Basic Accidental Death and Dismemberment Plan provides accident insurance 24 hours a day, anywhere in the world.

ELIGIBILITY

All active full-time Paramedics of CUPE Local 5734 under the age of 75 who work at least 20 hours per week are automatically covered after having worked 3 months continuous employment.

YOUR BENEFITS

You are automatically covered for a principal sum of one and a half (1.5) times **Salary**, subject to a maximum of $200,000.

*__Salary__ means an employee's basic annual earnings at the time of accident, excluding bonus and overtime. For hourly employees, earnings are based on the average number of hours worked during the previous 12 months.

The following benefits are provided if the loss occurs as a result of an accident within one year from the date of the accident:

Accidental Death & Dismemberment, Loss of Use and Paralysis

For Accidental Loss of:	Percent of Principal Sum
Life	100%
Both Arms or Both Legs	200%*
Speech and Hearing	100%
Both Hands, Both Feet or Sight of Both Eyes or a combination of any two of a Hand, a Foot or Sight of One Eye	100%
One Arm or One Leg	80%
One Hand, One Foot or Sight of One Eye	75%
Speech or Hearing	75%
Thumb and Index Finger of Same Hand	33%
Hearing in One Ear	33%
All Toes of One Foot	25%
For Accidental Loss of Use of:	
Both Arms or Both Legs or a Combination of An Arm and a Leg	200%*
Both Hands or Both Feet or a Combination of A Hand and a Foot	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Thumb and Index Finger of Same Hand	33%
Paralysis	
Quadriplegia	200%*
Paraplegia	200%*
Hemiplegia	200%*

* to a maximum of $1,500,000

- *Brain Damage*

This benefit will pay 100% of the principal sum for brain damage, if an accidental bodily injury results in brain damage to you. The benefit amount for brain damage will be paid if:

1) brain damage begins, and is diagnosed by a physician, within 30 days after the accident;
2) you are in a hospital or other licensed facility, to receive medically necessary treatment for brain damage, prescribed and supervised by a physician, within the first 30 days following the accident;
3) brain damage continues for 12 consecutive month; and
4) a physician determines brain damage is permanent, complete and irreversible at the end of the 12 consecutive months.

If you die within 365 days after the accident, then the benefit will pay a lump sum equal to your principal sum, less any benefit amount for brain damage already paid.

- *Coma*

This benefit will pay 1% of the principal sum if accidental bodily injury causes you to:

1) lapse into a coma within 30 days after the accident;
2) remain in a coma for 30 consecutive days; and
3) be confined to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician, within the first 30 days following the accident.

The benefit amount for coma is payable monthly up to 100% of the principal sum.

Brief lapses from a coma will not be considered an interruption of the consecutive 30 day period, or cause a discontinuance in payment, if the lapses and subsequent coma recurrences are due to the same accident.

The coma monthly payment will be made until the earliest of the date:

1) you die;
2) you are no longer in a Coma; or
3) total payments equal 100% of the principal sum.

If you die within 365 days after the accident, then the benefit will pay a lump sum equal to your principal sum, less any benefit amount for coma already paid.

Maximum Payment for Multiple Losses and Multiple Benefits

If you are entitled to receive payment of multiple benefit amounts as a result of one (1) covered accident, then the maximum we will pay for all benefits shall not exceed the principal sum with the exception of Loss of Both Arms or Both Legs, Loss of Use of Both Arms or Both Legs or a Combination of an Arm and a Leg, Quadriplegia, Paraplegia or Hemiplegia. In no event will the maximum amount payable exceed 200% of the principal sum.

TERMS AND CONDITIONS

Definitions:

"Loss" with reference to speech means the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices; with reference to hearing means the permanent, irrecoverable and total deafness, with an auditory threshold of more than 90 decibels in each ear which cannot be corrected by any aid or device; and with reference to sight means the permanent loss of vision, remaining vision must be no better than 20/200 using a corrective aid or device.

"Loss" with reference to hand or foot means complete severance through or above the metacarpal phalangeal joint of at least four fingers or three fingers and a thumb or the ankle joint; with reference to arm or leg means complete severance through or above the elbow or knee joint; with reference to thumb and index finger means complete severance through the metacarpal phalangeal joints of the thumb and index finger of the same hand; and with reference to toes means complete severance of all toes on a foot. We will consider such severance a loss even if the specified body part is later reattached. If the reattachment fails and amputation becomes necessary, then we will not pay an additional amount for such amputation.

"Paralysis" means complete and irreversible loss of all motion and all practical use of an arm or leg provided the loss is continuous for 365 days.

"Loss of Use" means the permanent and total inability of the specified body part to function.

Exposure & Disappearance

If you have not been found within one (1) year of the disappearance, stranding, sinking, or wrecking of any conveyance in which you were an occupant at the time of the accident, then it will be assumed, subject to all other terms and conditions of the policy, that you have suffered Loss of Life insured under the policy.

Accident includes unavoidable exposure to elements.

Beneficiary Designation

You have the right to designate a beneficiary. All beneficiary designations must be:

1) in writing;
2) filed with the administrator; and
3) provided to the insurance company at the time of claim or at such other time as they may require.

You, and no one else, unless there is an irrevocable assignment, have the right to change the beneficiary except as set forth above. You do not need the consent of anyone to do so. All beneficiary changes must be:

1) in writing;
2) filed with the administrator; and
3) provided to the insurance company at the time of claim or at such other time as they may require.

The benefit amount for covered loss of life will be paid to the beneficiary designated by you.

If you have not chosen a beneficiary or if there is no beneficiary alive when the insured person dies, then the insurance company will pay the benefit amount for loss of life to the first surviving party in the following order:

1) your spouse;
2) in equal shares to your surviving children;
3) in equal shares to your surviving parents;
4) in equal shares to your surviving brothers and sisters;
5) your estate.

ADDITIONAL BENEFITS

- ***Child Care Expense***

This benefit will reimburse child care expenses up to $5,000 annually for each eligible dependent child if accidental bodily injury causes your covered loss of life. This insurance applies only if you have a dependent child under the age of 13 years for whom child care expenses are incurred within 365 days of your covered loss of life.

This benefit will reimburse child care expenses for each eligible dependent child. However, the total payment will not exceed $25,000 regardless of the number of dependent children for whom payment is made.

Child care expenses shall be paid to the natural person who incurs such expenses for the dependent child.

- ***Education Expense***

This benefit will reimburse education expense up to $7,500 annually for each eligible dependent child if accidental bodily injury causes your covered loss of life. This insurance applies only if you have a dependent child at the time of a covered loss of life who:

1) is enrolled as a full-time student at an institution of higher learning on the date of your covered loss of life; or

2) subsequently enrols as a full-time student at an institution of higher learning within 2 years following the date of your covered loss of life; and
3) incurs education expense.

This benefit will reimburse education expenses for each eligible dependent child. However, the total annual payment for each dependent child will not exceed $7,500. The education expense payment is limited to 4 consecutive years for each dependent child. In no event will the total payment exceed $50,000.

The benefit amount for education expense shall be paid to the natural person who incurs the expense.

- ***Family Travel Expense***

This benefit will reimburse expenses up to $15,000 for the actual costs incurred by an immediate family member for temporary lodging, transportation and meals while travelling to and from visits with you, if within one (1) year of an accidental bodily injury which causes you to suffer a covered loss:

1) you are confined in a hospital not less than fifty (50 km) kilometres from your city of permanent residence; and
2) the attending physician recommends the personal attendance of an immediate family member.

The benefit amount for family travel expense will be paid to the natural person who incurs the expense.

- ***Funeral Expense***

This benefit will reimburse funeral expense up to $5,000 if accidental bodily injury causes your covered loss of life.

The benefit amount for funeral expense will be paid to the natural person who incurs the expense.

- ***Home Alteration or Vehicle Modification***

  This benefit will reimburse charges up to $15,000 for home alteration and up to $15,000 for vehicle modification if a covered loss due to an accidental bodily injury requires you to incur expenses for home alteration or vehicle modification. The expenses for home alteration or vehicle modification must be incurred within 24 months after the accidental bodily injury.

  The benefit amount for home alteration or vehicle modification is payable if:

  1) a physician certifies that the home alteration or vehicle modification is needed to accommodate your physical disability;
  2) the home alteration or vehicle modification is made by people experienced in such home alteration or vehicle modification;
  3) the home alteration or vehicle modification is in compliance with any applicable laws or requirements for approval by the appropriate governmental authority in the jurisdiction where the services are rendered; and
  4) the home alteration or vehicle modification expenses do not exceed the usual level of charges for similar alterations and modifications in the jurisdiction where the expenses are incurred.

  The benefit amount for home alteration and vehicle modification is payable to the natural person who incurs the expense.

  In no event will the total payments for home alteration and vehicle modification exceed $15,000.

- ***Home Health Care:***

  This benefit will reimburse charges up to $5,000 if a covered loss due to an accidental bodily injury causes your confinement to home after a hospital stay of 15 days. The expenses that are the subject of the benefit amount for home health care must be incurred within 18 months after the accidental bodily injury. The benefit amount for home health care is payable on an excess basis. The insurance company will determine the charges for home health care. It will then reduce that amount by

amounts already paid or payable by any other plan and it will pay the resulting benefit amount. In no event will the insurance company pay more than $5,000.

No benefit amount for home health care shall be paid if:

1) treatment is educational, experimental or investigational or does not constitute accepted medical practice; or
2) services are provided by a person who is an immediate family member.

- ***Identification Expense***

This benefit will reimburse expenses up to $15,000 for the reasonable transportation and accommodations costs incurred by an immediate family member, if accidental bodily injury causes your covered loss of life within one (1) year of an accidental bodily injury and:

1) the presence of an immediate family member is requested by the police or a similar governmental authority; and
2) the loss of life occurs not less than one hundred and fifty (150 km) kilometres from your city of permanent residence.

The benefit amount for identification expense will be paid to the natural person who incurs the expense.

- ***In-Hospital***

This benefit will pay $100 after an elimination period of 3 days for each day you are in-hospital, if an accidental bodily injury causes you to suffer a covered loss which results in you being in-hospital. The in-hospital benefit amount will not be paid for more than 30 days.

The in-hospital benefit amount will be paid until the earliest of the date:

1) you die;
2) you are no longer in-hospital; or
3) 30 days has elapsed.

If you are discharged from the hospital and the same accident causes you to be in-hospital again within 3 days after discharge, then any time in the hospital will count to satisfy the elimination period. However, in no event will total payment of the in-hospital benefit amount exceed 30 days.

- ***Occupational Human Immunodeficiency Virus (HIV)***

This benefit will pay you 25% of the principal sum, maximum of $50,000 if an occupational injury causes you to be HIV-seropositive no sooner than 72 hours but no later than 180 days after the date of such occupational injury.

Occupational Injury means an accidental bodily fluid exposure sustained by you during the policy period and while you are performing duties as a health care professional in your capacity as an employee of the City of Cornwall.

Accidental bodily fluid exposure means the occurrence of any of the following documented incidents that may place you at risk of human immunodeficiency virus (HIV):

1) a percutaneous injury such as a needlestick, bite or cut with a sharp object;
2) contact of mucous membranes or skin with blood, tissues or other bodily fluids; or
3) similar degrees of exposure to other bodily fluids.

You must:

1) report any occupational injury in writing to the policyholder and employer, if different from the policyholder. The report must be made within 72 hours after the occupational injury. A copy of the workers' compensation report must be submitted to the insurance company within 30 days after the occupational injury giving rise to the claim.
2) submit to testing for human immunodeficiency virus (HIV) at a laboratory or similar facility licensed to perform such testing within 72 hours after the occupational injury. If the test results indicate you are HIV-seropositive, then the HIV will be deemed to have been present before the occupational injury and insurance under the policy does not apply. If the test results indicate you are HIV-seronegative, then you must resubmit to HIV testing no sooner

than 150 nor more than 180 days after the occupational injury at a laboratory or similar facility licensed to perform such testing. If the retesting indicates you are HIV-seropositive, then insurance under the policy applies. If the retesting indicates you are HIV-seronegative, then insurance under the policy does not apply.

The insurance company will not pay for any expenses incurred for testing, unless required by law. Failure to comply with the above reporting and testing procedures will invalidate this insurance.

Limitation on Occupational Human Immunodeficiency Virus: The benefit amount for Occupational Human Immunodeficiency Virus does not apply to loss caused by or resulting from, directly or indirectly, any of the following:

Your HIV-seropositivity that is:

1) first diagnosed prior to the date you became insured under the policy;
2) directly related to any signs or symptoms of HIV infection for which you sought medical treatment prior to becoming insured under the policy;
3) not caused by a documented occupational injury; or
4) an occupational injury that occurs prior to the date you became insured under the policy.

- ***Occupational Hepatitis***

This benefit will pay you 25% of the principal sum, maximum of $50,000 if an occupational injury causes you to be Hepatitis-seropositive no sooner than 72 hours but no later than 180 days after the date of such occupational injury.

Occupational Injury means an accidental bodily fluid exposure sustained by you during the policy period and while you are performing duties as a health care professional in your capacity as an employee of the City of Cornwall.

Accidental bodily fluid exposure means the occurrence of any of the following documented incidents that may place you at risk of Hepatitis:

1) a percutaneous injury such as a needlestick, bite or cut with a sharp object;

2) contact of mucous membranes or skin with blood, tissues or other bodily fluids; or
3) similar degrees of exposure to other bodily fluids.

You must:

1) report any occupational injury in writing to the policyholder and employer, if different from the policyholder. The report must be made within 72 hours after the occupational injury. A copy of the workers' compensation report must be submitted to the insurance company within 30 days after the occupational injury giving rise to the claim.
2) submit to hepatitis testing at a laboratory or similar facility licensed to perform such testing within 72 hours after the occupational injury. If the test results indicate you are Hepatitis-seropositive, then the hepatitis virus will be deemed to have been present before the occupational injury and insurance under the policy does not apply. If the test results indicate you are Hepatitis-seronegative, then the hepatitis virus was not present before the occupational injury and you must resubmit to hepatitis testing no sooner than 150 nor more than 180 days after the occupational injury at a laboratory or similar facility licensed to perform such testing. If the retesting indicates you are Hepatitis-seropositive, then insurance under the policy applies. If the retesting indicates you are Hepatitis -seronegative, then insurance under the policy does not apply.

The insurance company will not pay for any expenses incurred for testing, unless required by law. Failure to comply with the above reporting and testing procedures will invalidate this insurance.

Limitations on Occupational Hepatitis: The benefit amount for Occupational Hepatitis insurance does not apply to loss caused by or resulting from, directly or indirectly, any of the following:

Your Hepatitis-seropositivity that is:

1) first diagnosed prior to the date you became insured under the policy;
2) directly related to any signs or symptoms of hepatitis infection for which you sought medical treatment prior to becoming insured under the policy;
3) not caused by a documented Occupational Injury;

4) an Occupational Injury that occurs prior to the date you became insured under the policy.

- ***Parent Care:***

  This benefit will pay $5,000 in equal shares to each of your dependent parents who is receiving support and care provided by you (as evidenced by income tax returns showing such parent as a dependent), to a maximum of $20,000, if you suffer an accidental bodily injury resulting in a covered loss of life.

- ***Psychological Therapy Expense***

  This benefit will reimburse the reasonable and customary expenses up to $5,000 for medically necessary counselling for a mental or nervous disorder by a physician, whether on an out-patient basis, in a hospital or any other medical facility licensed to provide such treatment if an accidental bodily injury causes you to suffer a covered loss resulting in a physician's determination that psychological therapy is required for:

  1) you; or
  2) your dependent.

  The benefit amount for psychological therapy expense is s payable on an excess basis. The insurance company will determine the charge for the psychological therapy expense and will then reduce that amount by amounts already paid or payable by any other plan. The insurance company will pay the resulting benefit amount, but in no event will it pay more than $5,000.

  The benefit amount for psychological therapy expense will be paid to the natural person who incurs the expense.

  The benefit amount for psychological therapy expense will be paid until the earlier of the date on which:

  1) $5,000 has been paid; or
  2) 2 years have elapsed from the date of a covered loss.

- ***Rehabilitation Expense***

If an accidental bodily injury causes you to suffer a covered loss which:

1) prevents you from performing all the duties of your regular occupation; and
2) requires you to obtain Rehabilitation, as determined by a physician

then this benefit will reimburse the reasonable and customary charges up to $15,000 for treatment, other than psychological therapy, intended to prepare you for work in any gainful occupation, including your regular occupation that is:

1) provided by a therapist licensed, registered, or certified to perform such treatment; or
2) provided in a hospital or other facility, which is licensed to provide such treatment.

The rehabilitation must take place under the direction of a physician.

The benefit amount for rehabilitation expense is payable on an excess basis. The insurance company will determine the charge for the rehabilitation expense and will then reduce that amount by amounts already paid or payable by any other plan. The insurance company will pay the resulting benefit amount, but in no event will it pay more than $15,000.
The benefit amount for rehabilitation expense will be paid to the natural person who incurs the expense.

The benefit amount for rehabilitation expense will be paid until the earlier of the date on which:

1) $15,000 has been paid; or
2) 2 years have elapsed from the date of the accidental bodily injury.

- ***Repatriation***

  This benefit will reimburse expenses up to $15,000 for the actual costs for preparation of the body for burial or cremation and shipment of the body to your city of permanent residence, if within one (1) year of an accidental bodily injury you suffer a covered loss of life not less than fifty (50 km) kilometres away from your city of permanent residence.

  The benefit amount for repatriation expense will be paid to the natural person who incurs the expense.

- ***Seat Belt & Occupant Protection Device***

  This benefit will pay 10% of the principal sum if you suffer an accidental bodily injury resulting in a covered loss of life while you are operating or riding in a private passenger automobile, and using a seat belt. The seat belt must have been properly secured and used in accordance with the recommendations of its manufacturer.

  This benefit will also pay 10% of the principal sum if you suffer an accidental bodily injury as set forth above and you are positioned in a seat protected by a properly deployed occupant protection device. Occupant protection device means either an air bag, which inflates for added protection to the head and chest areas, or any other personal safety restraint system other than a seat belt. The benefit amount for an occupant protection device will only be paid if a benefit amount for seat belt is paid.

  Verification of the actual use of the seat belt and proper operation of the occupant protection device at the time of the accident must be part of an official report of such accident or be certified, in writing, by an investigating police officer.

  In no event will a benefit amount for seat belt be paid if you are operating or riding as a passenger in any vehicle used for a race or contest of any type.

  In no event will the total payments for seat belt and occupant protection device exceed 20% of the principal sum.

- *Spouse Employment Training Expense*

  If an accidental bodily injury causes your covered loss of life then this benefit will reimburse the actual costs incurred by your spouse for tuition, fees, room and board, required books and course supplies billed by an institution of higher learning that are incurred for the purpose of your spouse obtaining or refreshing skills needed for employment.

  This insurance applies only if your surviving spouse incurs employment training expense within three (3) years following the date of your covered loss of life. In no event will the total payment for this benefit exceed $15,000.

  The benefit amount for spouse employment training expense will be paid to the natural person who incurs the expense.

- *Vocational Training Expense*

  If you suffer a covered loss due to an accidental bodily injury then this benefit will reimburse the actual costs incurred for tuition, fees, room and board, required books and course supplies, billed by an institution of higher learning for training that is intended to prepare you for work in any gainful occupation.

  The benefit amount for vocational training expense will be paid to the natural person who incurs the expense.

  The benefit amount for vocational training expense will be paid until the earlier of the date on which:

  1) $15,000 has been paid; or
  2) two (2) years have elapsed from the date of the accidental bodily injury.

TERMINATION OF INSURANCE

Your insurance automatically terminates on the earliest of:

1) the termination date of the policy;
2) the expiration of the period for which required premium has been paid for such you;
3) the date on which you no longer meet the eligibility criteria.

Upon termination, your insurance may continue, subject to the City of Cornwall's employment policy, as follows:

1) if you are on temporary lay-off, then insurance may continue for the full period of such lay-off but not for more than three hundred and sixty-five (365) days after the date on which such lay off begins;
2) if you are on a leave of absence, then the insurance may continue for the full period of the leave of absence but not for more than three hundred and sixty-five (365) days after the date on which such leave begins;
3) if you are absent from work due to an authorized family or medical leave, then insurance may continue for the full period of the leave but not for more than three hundred and sixty-five (365) days after the date on which such leave begins unless a longer period is agreed to.

Continuation of insurance is subject to the payment of premium.

Conversion Privilege

In the event your insurance under the policy ceases for any reason other than termination of the policy, you are eligible to purchase an individual accident insurance policy.

In order to convert this insurance to an individual accident insurance policy, you must submit to us or our authorized representative:

1) a completed, written application; and
2) the required premium

for the individual accident insurance policy within thirty-one (31) days after your insurance ended.

The individual accident insurance policy will:

1) be issued without evidence of insurability;
2) provide insurance only for loss of life and dismemberment that is most similar to, but not greater than, the terminated insurance;
3) not pay for the same loss for which benefits have already been paid under the policy;
4) provide a benefit amount which will be equal to your benefit amount under the policy, subject to a maximum benefit amount of $200,000; and
5) be subject to individual policy terms and conditions.

EXCLUSIONS

There are certain situations we do not cover in our policy. These include:

Owned or Leased Aircraft

- Loss caused by or resulting from, directly or indirectly, you being in, entering, or exiting any aircraft owned, leased or operated by your employer or on your employer's behalf; or operated by an employee of your employer on your employer's behalf.

Pilot or Crew

- Loss caused by or resulting from, directly or indirectly, you riding as a passenger in, entering, or exiting any aircraft while acting or training as a pilot or crew member.

Disease or Illness

- Loss caused by or resulting from, directly or indirectly, your emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions or medical or surgical treatment thereof. This exclusion does not apply to bacterial infection caused by an accident or accidental consumption of a substance contaminated by bacteria.

Incarceration

- Loss caused by or resulting from, directly or indirectly any occurrence while you are incarcerated after conviction.

Service in the Armed Forces

- Loss caused by or resulting from, directly or indirectly, you participating in military action while in active military service with the armed forces of any country or established international authority. However, this exclusion does not apply to the first sixty (60) consecutive days of active military service with the armed forces of any country or established international authority.

Suicide or Intentional Injury

- Loss caused by or resulting from, directly or indirectly, your suicide, attempted suicide or intentionally self-inflicted injury.

Trade Sanctions

- Loss when the government of Canada has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss; or there is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

War

- Loss caused by or resulting from, directly or indirectly, a declared or undeclared war. Declared or undeclared war does not include acts of terrorism.

This description is a summary of the principal features of the Plan, which is governed by the terms of the insurance contract with Chubb Insurance Company of Canada under policy 9907-45-62.

Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

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).

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.