

# your group benefits

Contract Number: 103613 and 153613

Effective: November 1, 2019

Issued: January 24, 2020



## Airline Hotels

Saskatchewan - Part-time non-union employees



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# How to Connect with Sun Life Financial



## Questions?

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

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

## Plan Member Services

Download the my Sun Life Mobile App!

- Free from the Apple App Store or Google Play, anytime
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit [www.mysunlife.ca](http://www.mysunlife.ca) to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

## Access to mysunlife website

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

## Special Authorization Program

For the form, call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212

## List of covered drugs, including their applicable reimbursement level

Call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212

## Your Drug Card

Provided by your employer or online at [www.mysunlife.ca](http://www.mysunlife.ca).

*Note: If you have refused Extended Health Care coverage under this plan, this drug card does not apply to you.*

## All other inquiries

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

# Benefit Summary



This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

## General Information

<b>We, our and us</b>	Throughout this booklet, <i>we</i> , <i>our</i> and <i>us</i> mean Sun Life Assurance Company of Canada
<b>Waiting period</b>	3 months of continuous employment  Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
<b>Termination</b>	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the <i>General Information</i> section of this booklet.

## Extended Health Care - Contract Number 153613

<b>Benefit year</b>	November 1, 2019 to December 31, 2019, and then from January 1 to December 31
<b>Deductible</b>	None
<b>Reimbursement level</b>	
<i>Drug card plan</i>	Included
<i>Prescription drugs</i>	80%
	Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under <i>Drug evaluation</i>
	We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:
	<ul style="list-style-type: none"><li>• drugs that legally require a prescription</li><li>• life-sustaining drugs that may not legally require a prescription</li><li>• compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN</li><li>• diabetic supplies, excluding alcohol, swabs and automatic jet injectors</li><li>• vaccines</li><li>• intrauterine devices (IUDs) and diaphragms</li><li>• varicose vein injections</li><li>• injectable drugs and vitamins.</li><li>• synovial fluid replacement.</li></ul>
	There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.

*Dispensing fee*

Eligible expenses for the dispensing fee are limited to \$5 for each prescription or refill

*Drug substitution limit*

We will not cover charges above the lowest priced equivalent drug unless the doctor specifies in writing that no substitution for the prescribed drug may be made

**Effective January 1, 2020**

*Prescription drugs*

Drugs and supplies have been evaluated based on their clinical and cost effectiveness and then classified under the Reformulary Group's formulary, the *Reformulary*, into 3 tiers accordingly:

**Tier 1** – 100%, for selected best value drugs and supplies. The majority of covered drugs and supplies are classified in Tier 1.

**Tier 2** – 70% for selected drugs and supplies, where better value alternatives exist under Tier 1.

**Tier 3** – 40% for selected drugs and supplies, where better value alternatives exist under Tier 1 or Tier 2.

*Drugs and supplies not included in the above tiers*

Drugs and supplies are reviewed on a regular basis and classified in one of the above tiers. There are certain drugs and supplies that have not yet been classified. Until such time, they will be paid at Tier 1 reimbursement percentage.

Maximum of \$2,500 per person per benefit year

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

We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- selected drugs and supplies listed in the Reformulary Group's formulary, the *Reformulary*
- drugs that legally require a prescription
- life-sustaining drugs that may not legally require a prescription
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN
- diabetic supplies, excluding alcohol, swabs and automatic jet injectors.
- vaccines
- intrauterine devices (IUDs) and diaphragms
- varicose vein injections
- injectable drugs and vitamins.
- synovial fluid replacement.

There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.

*Dispensing fee*

Eligible expenses for the dispensing fee are limited to \$5 for each prescription or refill

*Drug substitution limit*

The following limit applies to drugs that have not yet been classified in one of the tiers:

We will not cover charges above the lowest priced equivalent drug unless we specifically approve them. To assess the medical necessity of a higher priced drug, we will require the covered person and the attending doctor to complete and submit an exception form.

**Termination**

When you retire or reach age 70, whichever is earlier

## Dental Care - Contract Number 153613

<b>Benefit year</b>	November 1, 2019 to December 31, 2019, and then from January 1 to December 31
<b>Deductible</b>	None
<b>Fee guide</b>	The current fee guide for general practitioners in the province where the employee lives, regardless of where the treatment is received
<b>Reimbursement level</b>	
<i>Preventive procedures</i>	50%
<i>Basic dental procedures</i>	40%
<b>Maximum benefit</b>	
<i>Benefit year maximum</i>	\$750 per person
	If your coverage starts in the second half of a benefit year, the maximum amount for that benefit year will be reduced by 50%
<b>Termination</b>	When you retire or reach age 70, whichever is earlier

## Critical Illness - Contract Number 103613 (including Best Doctors services)

### Employee Optional Critical Illness

<b>Amount</b>	You can choose coverage in units of \$10,000 Maximum – \$200,000 Minimum – \$20,000
<b>Proof of good health</b>	Approval required on the initial optional amount of coverage, except for the first \$30,000 if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee
<b>Termination</b>	When you retire or reach age 70, whichever is earlier. In addition, your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain.

### Spouse Optional Critical Illness

<b>Amount</b>	You can choose coverage in units of \$10,000 Maximum – \$200,000 Minimum – \$20,000
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<b>Proof of good health</b>	Approval required on the initial optional amount of coverage, except for the first \$20,000 if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee
<b>Termination</b>	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier. In addition, your spouse's coverage will end on the date a Critical Illness benefit is paid for a covered condition which your spouse sustains.

## Child Optional Critical Illness

<b>Amount</b>	You can choose coverage in units of \$5,000 per child Maximum – \$20,000
<b>Proof of good health</b>	Approval required on the initial optional amount of coverage, except if the request for coverage is made within 31 days of eligibility, and any increase in that coverage requested by the employee
<b>Termination</b>	When you retire or reach age 70, whichever is earlier. In addition, coverage for any child will end on the date a Critical Illness benefit is paid for a covered condition which that child sustains.

## Life - Contract Number 103613

### Employee Basic Life

<b>Amount</b>	1 times your annual basic earnings rounded to the next higher \$1,000 Maximum – \$300,000
<b>Reduction</b>	Coverage is reduced to 50% of the above amount when you reach age 65  If you continue, or begin, to work after having reached age 65, we calculate the amount for which you would have been eligible if you had not already reached age 65, then, we apply the above reduction clause to calculate the amount for which you are eligible.
<b>Termination</b>	When you retire or reach age 70, whichever is earlier

### Employee Optional Life

<b>Amount</b>	You can choose coverage in units of \$10,000 Maximum – \$250,000
<b>Proof of good health</b>	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
<b>Termination</b>	When you retire or reach age 70, whichever is earlier

## Spouse Optional Life

<b>Amount</b>	You can choose coverage in units of \$10,000 Maximum – \$250,000
<b>Proof of good health</b>	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
<b>Termination</b>	When you retire or reach age 70, or when your spouse reaches age 70, whichever is earlier

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## Child Optional Life

<b>Amount</b>	You can choose coverage in units of \$5,000 per child Maximum – \$25,000
<b>Proof of good health</b>	Approval required on the initial optional amount of coverage, unless enrolment is made within 31 days of the eligibility date, and any increase in that coverage requested by the employee
<b>Termination</b>	When you retire or reach age 70, whichever is earlier

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## Accidental Death and Dismemberment - Contract Number 103613

### Employee Accidental Death and Dismemberment

<b>Amount</b>	Equal to Employee Basic Life coverage
<b>Termination</b>	When you retire or reach age 70, whichever is earlier

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# Making Claims



There are time limits for making claims. You can find more on these time limits in the following chart. **If you fail to meet these time limits, you may not be entitled to some or all benefit payments.**

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

## Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	<p>Ask your employer for the form to complete, or get the form on our website.</p> <p>You can also submit claims for some expenses electronically. For more information, ask your employer.</p>	<p>Up to the earlier of the following dates:</p> <ul style="list-style-type: none"> <li>• 90 days after the end of the benefit year during which the expense is incurred, or</li> <li>• 90 days after the end of your Extended Health Care coverage.</li> </ul>
Dental Care	<p>Ask your employer for the form to complete, or get the form on our website.</p> <p>The dentist will have to complete a section of the form.</p> <p>You can also submit claims for some expenses electronically. For more information, ask your employer.</p>	<p>Up to the earlier of the following dates:</p> <ul style="list-style-type: none"> <li>• 90 days after the end of the benefit year during which the expense is incurred, or</li> <li>• 90 days after the end of your Dental Care coverage.</li> </ul> <p>If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information.</p>

Type of claim	Starting the claims process	Limits and special instructions
Critical Illness coverage	Contact us to get the proper claim form.	<p><b>Initial contact with Sun Life:</b> Within 30 days after the date of diagnosis or surgery.</p> <p><b>Proof of claim:</b> Up to 90 days after the date of diagnosis or surgery.</p> <p>Failure to contact us or furnish proof of claim within the above time limits does not invalidate the claim if the contact is made or the proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to contact us or furnish proof within the above time limits.</p>
Life and Accidental Death and Dismemberment coverage	Ask your employer to provide the claim forms.	<p><b>If the claim is a result of a death:</b> We must receive the claim form as soon as possible after the death occurred.</p> <p><b>For any loss other than death:</b> We must receive the claim form within 12 months after the loss.</p> <p><b>For coverage during total disability:</b> We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.</p>

# General Information



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

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

For administrative purposes, number 105713 will be used for the Critical Illness benefit under this contract.

**Have questions?** Need more information about your group benefits? Talk to your employer.

## Your group benefits

The contract holder, Deer Lodge Ltd., self-insures the following benefits:

- Extended Health Care
- Dental Care

This means Deer Lodge Ltd. 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.

## Who is eligible to receive benefits?

To be eligible for group benefits, you must reside in Canada and meet all the following conditions:

- you are a permanent employee working in Canada.
- you are actively working for your employer at least 15 hours a week.
- you have completed the waiting period indicated in the Benefit Summary.

**Your dependents become eligible** for coverage on the later of the following dates:

- on the date you become eligible for coverage, or
- on the date they become your dependent.

You must apply for coverage for yourself in order for your dependents to be eligible.

## Who qualifies as your dependent

Your dependent must be:

- your spouse or your child, and
- residing in Canada or the United States.

**Your spouse** qualifies as your dependent if they are your spouse in one of the following ways:

- by marriage.
- under any other formal union recognized by law.
- as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship.

You can only cover one spouse at a time.

**Your children and your spouse's children** (other than foster children) are eligible dependents if they are under age 21 and do not have a spouse.

A child who is a full-time student under age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse.

**If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse.

In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**

### How to enrol

*For you* – You must provide the proper enrolment information to Sun Life through your employer.

*For a dependent* – You must ask for dependent coverage.

If you or your dependents already have similar Extended Health Care or Dental Care coverage under this or another plan – You may refuse this coverage under this plan. If the other coverage ends at a later date, you can enrol for coverage under this plan then.

You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health.

- Employee Optional Life
- Spouse Optional Life
- Child Optional Life
- Employee Optional Critical Illness
- Spouse Optional Critical Illness
- Child Optional Critical Illness

### When coverage begins

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

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

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

- the date your coverage begins.
- the date you first have a dependent.

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

### Changes affecting your coverage

If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.

If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

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

## Updating your records

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

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

## Accessing your records

You may request copies of your records, including:

- your enrolment form or application for insurance.
- any written statements or other record about your health that you provided to Sun Life in applying for coverage.
- one copy of the insured contract.

We will not charge you for the first copy but we may charge a fee for further copies.

Need a copy of a document? Contact one of the following:

- our website at [www.mysunlife.ca](http://www.mysunlife.ca).
- our Customer Care centre, toll-free at 1-800-361-6212.

## When coverage ends

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

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

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

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

The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

## If you die while covered by this plan

Coverage for your dependents will continue until **the earlier of** the following dates:

- 24 months after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

When dependent coverage continues, it is subject to all other terms of the plan.

The continuation of coverage does not apply to Spouse and Child Optional Life and Optional Critical Illness.

## 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 continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

## Coordinating your benefits with another plan

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

When you have more than one plan, insurance industry standards determine which plan you should claim expenses from first.

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

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

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

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

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

## Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefits.

## Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

## Assignments

For Life benefits – You may not assign any rights or interests to anyone.

For all other benefits – We reserve the right to deny your request for an assignment.

## Definitions

Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits appear in the benefit sections.

<b>Accident</b>	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
<b>Basic earnings</b>	<p>Basic earnings are the employee's salary from the employer including any overtime earned on a regular basis, but not including any bonus or incentive pay.</p> <p>If you are a commissioned salesperson, basic earnings are your average earnings over the past 2 years, including commissions. If employed less than 2 years, basic earnings are your average earnings since your date of hire, including commissions.</p>
<b>Doctor</b>	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
<b>Illness</b>	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.
<b>Retirement date</b>	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

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# Extended Health Care



## 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 expenses that you incur while covered under this plan.

*Eligible expenses* mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

*Effective January 1, 2020: Eligible expenses* mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed. However, there are additional eligibility requirements that apply to drugs (see *Special authorization program* for details).

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

*Reasonable and customary charges* mean:

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

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

### Claiming when the expense is incurred

You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies.

The benefit year is indicated in the Benefit Summary.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

### Reimbursement level

Claims will be paid up to the reimbursement level under this plan.

**For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

## Prescription drugs

### Prescription drugs

We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.

### Quantity limit

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.

## What is not covered

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.
- products to help you quit smoking.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

## Drug evaluation

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

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

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

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

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

## Prior authorization program

The prior authorization (PA) program applies to a limited number of drugs, where you must get approval in advance for coverage under the program.

In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form. You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

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

If not, your claim will be declined.

See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.

## Prescription drugs – Effective January 1, 2020

### Prescription drugs

We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.

## Quantity limit

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.

If you are prescribed a drug or supply that is not eligible under Tier 1, you can speak with your doctor as there may be another drug or supply that is payable at Tier 1 reimbursement percentage. If there is a medical reason why you cannot take a Tier 1 drug or supply, the Tier 2 or Tier 3 drug or supply may be covered at Tier 1 reimbursement percentage, provided that you and your doctor complete and submit an exception form and that the information meets our medical criteria. If the information provided meets our medical criteria, you will be covered for these drugs and supplies at Tier 1 reimbursement percentage. If not, you will be covered for these drugs and supplies at the tier reimbursement percentage under which they are classified.

Drugs and supplies are reviewed on a regular basis and may change tiers. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to view the most current information on your drug coverage and find out the reimbursement percentage for a specific drug or supply.

## What is not covered

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.
- products to help you quit smoking.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- contraceptives, other than oral contraceptives.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
- drugs and supplies, the high costs of which are not supported by demonstrated superior clinical effectiveness relative to cost of one or more alternatives available under the plan, as determined by *Reformulary Group*.

## Drug evaluation

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

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

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

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

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

## Special authorization program

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

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

If the information you and your doctor provide meets our medical criteria, you will be covered for these drugs and supplies at Tier 1 reimbursement percentage. If not, your claim will be declined.

See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our special authorization forms.

## When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

## Payments after coverage ends

If you are totally disabled, as defined in the contract, 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.

**If the Extended Health Care benefit ends**, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

- the accident occurred while you were covered, and
- you have the procedure 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 *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that we consider ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

## Integrating this plan with government programs

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

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

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

# Dental Care



## 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 specified in the Benefit Summary. 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.

We will base payments on the fee guide at the time the person receives the treatment.

### To decide what part of a procedure we will pay for:

- we will first find out if you could have had alternate, or other, dental procedures.
- we confirm that these alternate procedures are part of usual and accepted dental work and produced a similar result to the procedure that the dentist performed.

We will only pay the reasonable cost of the least expensive alternate procedure.

### 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 reasonable and customary charge for the final dental service.

### Claiming when the expense is incurred

You must claim an expense for the benefit year in which you incur the expense.

The benefit year is indicated in the Benefit Summary.

You incur an expense on the date your dentist performs a single appointment procedure.

For procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

### Reimbursement level

Claims will be paid up to the reimbursement level under this plan.

**For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

### Maximum benefit

Maximums are indicated in the Benefit Summary.

### Getting an estimate before you have certain procedures

For any major treatment or any procedure that will cost more than \$500, we suggest that you send us an estimate before the work is done. Here's what to expect:

- you will 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.

## Your dental services at a glance

Covered expenses	Details / Payment limits
<p><b>Preventive dental procedures</b> – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.</p>	
<b>Oral examinations</b>	<ul style="list-style-type: none"> <li>1 complete examination every 2 benefit years.</li> <li>1 recall examination every 9 months.</li> <li>emergency or specific examinations.</li> </ul>
<b>X-rays</b>	<ul style="list-style-type: none"> <li>1 complete series of x-rays or 1 panorex every 2 benefit years.</li> <li>1 set of bitewing x-rays every 9 months.</li> <li>x-rays to diagnose a symptom or examine progress of a certain course of treatment.</li> </ul>
<b>Other services</b>	<ul style="list-style-type: none"> <li>required consultations between two dentists.</li> <li>polishing (cleaning of teeth) and topical fluoride treatment once every 9 months.</li> <li>emergency or palliative services.</li> <li>diagnostic tests and laboratory examinations.</li> <li>removing impacted teeth and related anaesthesia.</li> <li>providing space maintainers for missing primary teeth.</li> <li>pit and fissure sealants.</li> <li>oral hygiene instruction once every 5 months, up to 2 sessions per benefit year.</li> </ul>
<p><b>Basic dental procedures</b> – Your dental benefits include the following procedures used to treat basic dental problems.</p>	
<b>Fillings</b>	<ul style="list-style-type: none"> <li>amalgam (silver) and composite or acrylic (white), or equivalent.</li> </ul>
<b>Extraction of teeth</b>	<ul style="list-style-type: none"> <li>removing teeth, except impacted teeth (<i>Preventive dental procedures</i>).</li> </ul>
<b>Basic restorations</b>	<ul style="list-style-type: none"> <li>prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.</li> </ul>
<b>Endodontics</b>	<ul style="list-style-type: none"> <li>root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.</li> </ul>
<b>Periodontics</b>	<ul style="list-style-type: none"> <li>treating disease of the gum and other supporting tissue.</li> <li>scaling and root planing, up to a combined maximum of 16 units of 15 minutes per benefit year.</li> <li>occlusal equilibration, up to a maximum of 8 units of 15 minutes per benefit year.</li> </ul>
<b>Oral surgery</b>	<ul style="list-style-type: none"> <li>surgery and related anaesthesia, other than the removal of impacted teeth (<i>Preventive dental procedures</i>).</li> </ul>
<b>Repair of dentures</b>	<ul style="list-style-type: none"> <li>repair of dentures.</li> </ul>
<b>Rebase or reline</b>	<ul style="list-style-type: none"> <li>rebase or reline of an existing partial or complete denture.</li> </ul>

## When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

## Payments after coverage ends

If the Dental Care benefit ends, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

- the accident occurred while you were covered, and
- you have the procedure 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.
- charges related to implants, including surgery charges.
- 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.

# Critical Illness



## General description of the coverage

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

**See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.**

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

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

<b>What we will pay</b>	<p>We will pay the Critical Illness benefit if, after the effective date of coverage, and while coverage is in force, you or your dependent (spouse or child) have a diagnosis of a covered condition, or you or your dependent have surgery for a covered condition, subject to the survival period. Claims will be assessed based on the Critical Illness provisions in effect on the date of diagnosis or surgery.</p> <p>The Critical Illness benefit is payable only on the first covered condition for which a diagnosis is effective, or surgery is performed, and the person's coverage then terminates. Such person may not become covered again under this benefit.</p> <p>We reserve the right to require examination of the covered person and confirmation of any diagnosis of or surgery for any covered condition, by a medical practitioner appointed by us in order for any Critical Illness benefit to become payable.</p>
<b>Diagnosis</b>	<p>Diagnosis means a written diagnosis by a physician or specialist physician, licensed and practicing in Canada, of the covered condition. Any diagnosis must be made while coverage is in force and will be effective as of the date it is established by the physician or specialist physician, as supported by the covered person's medical records. Any diagnosis of a covered condition that was made prior to the effective date of coverage will not be covered.</p>
<b>Life support</b>	<p>Life support means the covered person is under the regular care of a licensed physician or specialist physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.</p>
<b>Physician</b>	<p>Physician means a legally and professionally qualified medical practitioner practicing in Canada. The physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.</p>
<b>Specialist physician</b>	<p>Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a speciality examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.</p>

<i>Surgery</i>	Surgery means a medical operation performed on the covered person and recommended by a physician or specialist physician, licensed and practicing in Canada.
<i>Survival period</i>	Survival period means the period starting on the date of diagnosis of the critical condition and ending 30 days following the date of diagnosis of the critical condition, unless a covered condition described below expressly modifies this definition. The survival period does not include the number of days on life support. The covered person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.
<b>Who we will pay</b>	The Critical Illness benefit is payable to you or, in the event of your death, to your estate.
<b>Changes in coverage</b>	Changes in the amount of coverage or covered conditions may occur as the result of an employment status change or a change in plan design.
<i>Changes in the amount of coverage</i>	<p>If you are not actively working or a dependent is hospitalized (other than a newborn child) on the date a change occurs, refer to <i>Changes affecting your coverage</i> in the <i>General Information</i> section to understand the effective date of any change to the amount of Critical Illness coverage.</p> <p>The <i>Pre-existing conditions</i> provision under <i>What is not covered</i> will apply to increased amounts of coverage as described in that provision.</p>
<i>Other changes</i>	<p>If new Critical Illness conditions are added to this plan, the new Critical Illness conditions will only apply to:</p> <ul style="list-style-type: none"> <li>• employees who are actively working;</li> <li>• dependents who are not hospitalized (other than newborn children); and</li> <li>• persons already having Critical Illness coverage</li> </ul> <p>on the date that the change occurs. The effective date of coverage for the new covered conditions is the date of the change to the plan.</p> <p>If you are not actively working when the change occurs, the change will take effect when you return to active work and such date will be your effective date of coverage for the new covered conditions. If a dependent is hospitalized when the change occurs (other than a newborn child), the change will take effect when the dependent is discharged and resumes normal activities and such date will be the dependent's effective date of coverage for the new covered conditions.</p> <p>In all instances, we will:</p> <ul style="list-style-type: none"> <li>• apply the effective date of coverage to determine a person's eligibility for a Critical Illness benefit payment; and</li> <li>• apply the effective date of coverage for the new covered conditions to any exclusions or limitations under this plan, including the <i>Pre-existing conditions</i> provision. Such exclusions and limitations will be applied to the new covered conditions even if the explicit wording of this plan provides otherwise, including where: <ul style="list-style-type: none"> <li>• proof of good health was previously required for a person's coverage; or</li> <li>• the <i>Child moratorium period exclusion</i> previously applied or the child was born or adopted later than 10 months after the date the employee became covered for Child Critical Illness.</li> </ul> </li> </ul> <p>If the definition of a Critical Illness condition is changed, we will adjudicate any claim for a Critical Illness benefit based on the definition of that Critical Illness condition in effect on the date of the diagnosis or surgery, regardless of whether you were actively working or your dependent was hospitalized on the date of the change.</p>

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

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

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

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

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

**Covered conditions  
for employees,  
spouses and children**

***Aortic surgery***

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

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

***Aplastic anemia***

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

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

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

***Bacterial meningitis***

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

### ***Benign brain tumour***

The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

Exclusion:

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

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

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

Exclusions:

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date a person enrolls for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

- a diagnosis of benign brain tumour (covered or excluded under this coverage), no benefit will be payable for benign brain tumour for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for benign brain tumour for those additional amounts. All other coverage remains in force.

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

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

### ***Blindness***

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

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

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

### ***Cancer (life-threatening)***

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

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

Exclusions:

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

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

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

Moratorium Period Exclusion:

If, within 90 days following the later of:

- the date a person enrolls for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

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

***Coma***

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

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

Exclusions:

No benefit will be payable under this condition for:

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

***Coronary artery bypass surgery***

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

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

***Deafness***

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

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

***Dementia, including Alzheimer's disease***

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

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

The covered person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

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

Exclusion:

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

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

***Heart attack***

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

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

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

Exclusions:

No benefit will be payable under this condition for:

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

***Heart valve replacement or repair***

Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Exclusion:

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

***Kidney failure***

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

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

***Loss of independent existence***

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

Activities of daily living are:

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

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

***Loss of limbs***

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

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

***Loss of speech***

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

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

Exclusion:

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

***Major organ failure on waiting list***

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

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

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

***Major organ transplant***

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

***Motor neuron disease***

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

Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

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

***Multiple sclerosis***

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

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

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

***Occupational HIV infection***

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

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

- the date a person enrolls for such amount of coverage; or
- the effective date of such amount of coverage.

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

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

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

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

Exclusions:

No benefit will be payable under this condition if:

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

*Paralysis*

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

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

*Parkinson's disease*

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

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

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

Moratorium Period Exclusion:

If, within 1 year following the later of:

- the date a person enrolls for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

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

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

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

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

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

### ***Severe burns***

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

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

### ***Stroke (cerebrovascular accident)***

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

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

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

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

Exclusions:

No benefit will be payable under this condition for:

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

### **Covered conditions for children only**

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

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

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

For children:

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

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

References to a covered person include children.

***Cerebral palsy***

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

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

***Congenital heart disease***

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

Covered heart conditions:

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

The diagnosis of the heart condition must be:

- made by a specialist physician; and
- supported by cardiac imaging acceptable to us.

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

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

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

Procedures not covered by this definition are:

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

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

- by a specialist physician; and
- supported by cardiac imaging acceptable to us.

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

***Cystic fibrosis***

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

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

***Down's syndrome***

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

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

<p><b><i>Muscular dystrophy</i></b></p>	<p>Muscular dystrophy means a definite diagnosis of muscular dystrophy where the covered person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.</p> <p>The diagnosis of muscular dystrophy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.</p>
<p><b><i>Type 1 diabetes mellitus</i></b></p>	<p>Type 1 diabetes mellitus means a definite diagnosis where the covered person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.</p> <p>The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.</p>

## What is not covered

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

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

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

## Child moratorium period exclusion

Any child of yours or your spouse will be excluded from Critical Illness coverage if:

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

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

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

## Pre-existing conditions

For any amount of coverage that:

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

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

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

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

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

## **Portability**

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

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

At the time that you and/or your spouse apply to transfer group Critical Illness coverage to another critical illness policy, you or your spouse may also apply to transfer the group Critical Illness coverage for any covered children. We will not require the child's proof of good health. However, if either you or your spouse maintain coverage under this plan, the Critical Illness coverage for the child cannot be transferred.

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

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

## **Best Doctors**

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

If you or your spouse are covered for Critical Illness, you, your spouse, your children, your parents and your parents-in-law have access to Best Doctors. If only your children are covered for Critical Illness, no access to Best Doctors is provided.

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

## **Liability and responsibility of Sun Life**

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

Sun Life cannot guarantee the availability of Best Doctors services.

# Life Coverage



## 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.

**See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.**

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

<b>Who we will pay</b>	<p>If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us.</p> <p>If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.</p> <p>If a dependent dies, we will pay you the benefit for that dependent.</p> <p>For your spouse's optional coverage, we will pay the full amount of the benefit to the last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to you.</p> <p><b>Fact</b> There are different rules for designating a minor beneficiary, please refer to your contract for specific information.</p>
<b>Suicide</b>	<p>If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions.</p>
<b>Coverage during total disability</b>	<p>Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 65, whichever is earlier, as long as you are totally disabled. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.</p> <p>There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact your employer for details.</p>

## Converting Life coverage

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

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends because your Life coverage has ended, 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 that the Life coverage reduces or ends.

**Important**

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

# Accidental Death and Dismemberment



## General description of the coverage

Accidental Death and Dismemberment coverage provides benefits if you die or suffer any of the losses listed in the table under *What we will pay*, and it is due to an accident that occurs while covered. Any death benefit we will pay under this coverage is in addition to any Life coverage.

**See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.**

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

## What we will pay

We will pay this benefit if you are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage, as follows:

### TABLE OF LOSSES

Loss of life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	75%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33 1/3%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four toes on the same foot	25%
Loss of use of both arms or both legs	100%
Loss of use of both hands or both feet	100%
Loss of use of one arm or one leg	75%
Loss of use of one hand or one foot	75%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

### Remember...

- We only pay the largest percentage for injuries to the same limb resulting from the same accident.
- We will only pay up to 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay up to 200%.
- Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

### Limit on benefit amounts

If more than one person covered by the group contract is eligible for benefits resulting from the same accident, Sun Life will pay up to a maximum of \$3,000,000 for all claims related to the accident.

### Additional benefits

In addition to your Accidental Death and Dismemberment payment, we also offer additional benefits if you die or suffer a loss as a result of an accident. **There are specific conditions that apply to each benefit and you can get more information about when these benefits apply from your employer or Sun Life.**

Repatriation benefit: Pays up to \$10,000 for the return of your body if you die 100 kilometres or more away from your home.

Rehabilitation program: Pays up to \$10,000 of your expenses in a rehabilitation program.

Spouse occupational training benefit: Pays up to \$5,000 to your spouse for occupational training if you die.

Child education benefit: Pays 5% of the amount of coverage up to \$5,000, each year up to a maximum of 4 years, to cover a dependent child's tuition fees in a post-secondary school if you die.

Family transportation benefit: Pays up to \$5,000 for hotel accommodations and travel costs of an immediate family member if you are hospitalized 150 kilometres or more away from home.

## Coverage during total disability

If you become totally disabled while covered and premiums are no longer payable for Life coverage, this coverage will continue without the payment of premiums, but not past age 65.

Any amount of continued coverage follows the terms of this group plan when your total disability began.

## What is not covered

We will not pay for losses that result from **one or more** of the following actions:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.
- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- flying in an aircraft, descending from an aircraft or being exposed to any hazard related to an aircraft, while:
  - receiving flying lessons.
  - performing any duties in connection with the aircraft.
  - being flown for a parachute jump.
  - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence.

## Converting coverage

If you apply to convert your group Life coverage to an individual Life policy with Sun Life, you may have an Accidental Death benefit attached to the individual Life policy.

### **Important**

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

## Respecting your privacy

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

## You have a choice

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



## About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than one in six Canadians, in over 12,000 corporate, association, affinity and creditor groups across Canada.

Our Core values – integrity, service excellence, customer focus and building value – are at the heart of who we are and how we do business.

Sun Life Financial and its partners have operations in 22 key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

### Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

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