Sun Life Financial

your group benefits

INTUIT

Seasonal Québec Employees
Hired Prior to June 1, 2021

Contract Number 100179, 150019 and 9906 7281
Effective August 1, 2023 (Version 2)

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

Table of Contents

General Information 1
Classes 1
About this booklet 1
Eligibility 2
Who qualifies as your dependent 2
Enrolment 3
When coverage begins 4
Changes affecting your coverage 4
Updating your records 5
Accessing your records 5
When coverage ends 5
Replacement coverage 7
Making claims 7
Legal actions for insured benefits 7
Legal actions for self-insured benefits 8
Proof of disability 8
Coordination of benefits 8
Medical examination 10
Recovering overpayments 10
Definitions 10

Extended Health Care (Medicare Supplement) 11
Plan administrator 11
General description of the coverage 11
Deductible 12
Prescription drugs 12
Hospital expenses in your province 17
Expenses out of your province 17
Medical services and equipment 20
Gender affirmation procedures 23
Paramedical services 25
Contact lenses, eyeglasses or laser eye correction surgery 26
When coverage ends 27
Payments after coverage ends 27
What is not covered 27
Integration with government programs 28
When and how to make a claim 29
Lumino Health Virtual Care 29

Liability and responsibility of Sun Life 29

Emergency Travel Assistance 30
Plan administrator 30

Dental Care 36
Plan administrator 36
General description of the coverage 36
Deductible 37
Benefit year maximum 37
Predetermination 37
Preventive dental procedures 37
Basic dental procedures 38
When coverage ends 39
Payments after coverage ends 39
What is not covered 39
When and how to make a claim 40

Life Coverage 41
Insurer 41
General description of the coverage 41
Basic Life coverage for you 41
Optional Life coverage for you 41
Optional Life coverage for your spouse 41
Optional Life coverage for your children 42
Who we will pay 42
Suicide 43
Coverage during total disability 43
Converting Life coverage 44
When and how to make a claim 45

BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE .46

General Information

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

Classes

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

- Class C1 – Seasonal Non-Expert Fixed Term Contract / Maternity Leaves (Québec Employees) Hired Prior to June 1, 2021 (Québec Employees)
- Class D1 – Seasonal Expert (Québec Employees) Hired Prior to June 1, 2021 (Québec Employees)

About this booklet

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

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

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

The contract holder, Intuit Canada ULC, self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance

- Dental Care

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

Eligibility

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

- you are working on a contractual basis for the employer.
- you are actively working for the employer at least 20 hours a week.
- you have completed the waiting period.

Seasonal Workers covering maternity leaves

There is no waiting period for your group plan.

For all other employees

The waiting period for your group plan is 6 months of continuous employment.

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

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, until the last day of the month in which they reach age 22.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the last day of the month in which they reach age 25 (age of 26 for drugs listed in the Régie de l'assurance-maladie du Québec drug formulary) as long as the child is entirely dependent on you for financial support.

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

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

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

Enrolment

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

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

For your Optional Life coverage and your Spouse or Child Optional Life coverage, proof of good health will be required as specified in the *Life Coverage* section. Coverage will not take effect before Sun Life approves the proof of good health.

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.

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

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

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

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

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

Changes affecting your coverage

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

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

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

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

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

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

When coverage ends

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

dates:

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

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

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

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

However, if you die while covered by this plan, coverage for your dependents will continue, without premiums, 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 the benefit provision under which the dependent is covered terminates.

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

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

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

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

Definitions

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

Accident

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

Basic earnings

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

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.

Doctor

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

Illness

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

Retirement date

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

We, our and us

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

Extended Health Care
(Medicare Supplement)

Plan administrator

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

General description of the coverage

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

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

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

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

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

Reference to Doctor may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a doctor. For drugs, refer to *Other health professionals allowed to prescribe drugs.*

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Prescription drugs

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

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

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility, up to a lifetime maximum of $10,000 for each person.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

We will also cover the cost of products to help a person quit smoking that have a Drug Identification Number (DIN) and have been approved under *Drug evaluation*, or a Natural Product Number (NPN), up to a lifetime maximum of $500 for each person, provided that they are prescribed by a doctor or dentist and obtained from a pharmacist.

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

We will cover 100% of the cost of the above drugs and supplies.

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.
- 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), except as otherwise provided under the list of eligible expenses above.
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug evaluation

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

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

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

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

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

Pharmaceutical services (rendered by pharmacists)

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

Drug substitution limit

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

Prior authorization program

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

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

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

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.

- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

Reference Drug Program

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category.*

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.

- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

Québec drug insurance plan

Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements.

Persons age 65 or over

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

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

On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact your benefits

administrator to clarify your situation. Unfortunately, we cannot change your file without confirmation from your benefits administrator.

Other health professionals allowed to prescribe drugs

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

Hospital expenses in your province

We will cover 100% of the costs for hospital care in the province where you live.

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

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

The maximum amount payable is $20 per day up to a maximum of 180 days for treatment of an illness due to the same or related causes.

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

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

Expenses out of your province

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

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

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

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

Emergency services

We will pay 100% of the cost of covered emergency services.

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

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

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

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

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

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

Emergency services excluded from coverage

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

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

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 80% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

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

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

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $1,000,000 per person or, if lower, any other applicable lifetime maximum.

Medical services and equipment

We will cover 100% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $25,000 per person during any 3 consecutive benefit years.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically necessary,

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

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of $1,000 per person per benefit year.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, up to a maximum of $125 per person in a benefit year.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- wigs following chemotherapy or for total hair loss due to a medical condition, up to a maximum of $300 per person in a benefit year. Wigs do not require a doctor’s order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical

needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.

- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $350 per person in a benefit year.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $500 per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of $700 per person.
- Continuous Glucose Monitor (CGM), including receivers, transmitters, and sensors, for persons diagnosed with Type 1 or

Type 2 diabetes requiring insulin use, up to a combined maximum of $4,000 per person per benefit year. You must provide us with a doctor's note confirming both the diagnosis and insulin use.

- insulin pumps.

Gender affirmation procedures

We will cover 100% of the costs for the following gender affirmation procedures, up to a benefit year maximum of $10,000 per person and a lifetime maximum of $40,000 per person, provided you meet the *Eligibility requirements* set out below.

Eligible procedures:

- breast augmentation/augmentation mammoplasty.
- thyroid chondroplasty.
- laryngoplasty.
- permanent hair removal (laser or electrolysis) for pre-surgical areas, or for excessive facial or body hair.
- brow bone reduction/construction.
- jaw bone reduction/reshaping/contouring.
- rhinoplasty, blepharoplasty and rhytidectomy.
- liposuction of the waist.
- gluteal augmentation (lipofilling or implants).
- hairline reconstruction to correct a receding hairline.
- hysterectomy.
- vaginectomy.
- salpingo-oophorectomy.
- chest contouring/chest masculinization, including

liposuction/lipofilling done to provide additional contouring.

- implantation of penile and/or testicular prostheses.
- chin and cheek augmentation.
- pectoral implants.

We reserve the right to modify the above list of eligible expenses in the event there is a change in the list of procedures covered by any of the gender affirmation programs in a province or territory.

Eligibility requirements

- You must be under the care of a doctor for gender affirming care.
- You must be at least 18 years old and must have been diagnosed with gender dysphoria by a doctor.
- Prior approval is required. You and your doctor must complete the *Gender Affirmation application form*, and submit it to us.
- All procedures must be considered medically necessary by your doctor.
- All procedures must be performed in Canada.
- Only expenses incurred after your effective date for coverage under this benefit provision, and while this benefit provision is in force, will be eligible for reimbursement.

Before incurring an expense, you must call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212 to obtain the *Gender Affirmation application form*. We will assess all procedures based on the terms of this plan. We reserve the right to request details of procedures performed.

You may incur other expenses, such as drugs or paramedical services, related to gender affirming care. To determine if these other expenses are eligible under this plan, and any applicable benefit maximum, please refer to the *Prescription drugs*, *Paramedical services* or other applicable provisions of this Extended Health Care benefit.

What is not covered

We will not pay for the costs of:

- procedures payable or available under the medicare plan in your place of residence, regardless of whether you have applied to, or been accepted into, the gender affirmation program.
- travel or accommodations expenses.
- reversal of gender affirmation procedures.
- sperm preservation or cryopreservation of fertilized embryos.
- procedures related to fertility problems caused by gender affirming treatment and/or surgical care.

Paramedical services

We will cover 100% of the costs, up to a combined maximum of $1,000 per person per benefit year for all paramedical specialists listed below:

- licensed massage therapists.
- licensed speech therapists.
- licensed physiotherapists.
- licensed naturopaths.
- licensed acupuncturists.
- licensed audiologists.
- licensed dieticians.
- licensed occupational therapists.
- licensed osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year.
- licensed chiropractors, including a maximum of one x-ray examination each benefit year.

- licensed podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year.

We will not pay for the cost of services rendered by a podiatrist in Ontario or Alberta unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

We will cover 100% of the costs, up to a combined maximum of $4,000 per person per benefit year for all paramedical specialists listed below:

- licensed psychologists or social workers.
- licensed psychiatrists.
- licensed psychoanalysts or psychoanalysts who are active members of a provincial association approved by Sun Life.
- licensed psychotherapists or psychotherapists who are active members of a provincial association approved by Sun Life.
- clinical counsellors who are active members of a provincial association approved by Sun Life.
- marriage and family therapists who are active members of a provincial association approved by Sun Life.

Contact lenses, eyeglasses or laser eye correction surgery

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

We will cover 100% of these costs up to a maximum of $250 per person in a benefit year.

We will also cover 100% of the cost of visual training performed by a licensed optometrist, up to a lifetime maximum of $500 per person.

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

any kind, unless they are prescription glasses needed for the correction of vision.

When coverage ends

Extended Health Care coverage will end when the employee retires.

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

Payments after coverage ends

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

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

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

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

What is not covered

We will not pay for the costs of:

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

equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).

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

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

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

Integration with government programs

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

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

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

When and how to make a claim

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

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

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

Lumino Health Virtual Care

The services offered through Lumino Health Virtual Care are provided by Dialogue. These services are not insured or administered by Sun Life.

If you are covered for Extended Health Care coverage, you and your covered dependents will have access to Dialogue services.

Lumino Health Virtual Care offers a variety of services including access to medical professionals. To learn more about the services provided by Dialogue, or to use these services, please visit https://luminovc.dialogue.co/.

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 Dialogue.

Emergency Travel Assistance

Plan administrator

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

General description of the coverage

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

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

If you are faced with a medical emergency when travelling outside of the province where you live, Sun Life's Emergency Travel Assistance (ETA) provider can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Sun Life's ETA provider. If contact with Sun Life's ETA

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

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

Sun Life's ETA provider may arrange for:

On the spot medical assistance

Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities.

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

Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel.

Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Sun Life's ETA provider may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Sun Life's ETA provider, based on available medical

evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.

Meals and accommodations expenses

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

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

Travel expenses home if stranded

Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live:

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

If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified attendant to accompany them home. The attendant is subject to the approval of you or a member of your family.

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 for the return of a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from returning the vehicle.

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Sun Life's ETA provider will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

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

If you are covered under this group plan and certain other plans, we

will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association.

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

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Sun Life's ETA provider:

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

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

Limits on Emergency Travel Assistance coverage

There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before your departure.

Sun Life's ETA provider reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

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

Liability of Sun Life or Sun Life's ETA provider

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

Dental Care

Plan administrator

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

General description of the coverage

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

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

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

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

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

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

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

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than $1,500 per person for each benefit year for all services.

Predetermination

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

Preventive dental procedures

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

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

Oral examinations

1 complete examination every 24 months.

1 recall examination every 5 months, up to a maximum of 2 examinations per benefit year.

Emergency or specific examinations.

X-rays

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

1 set of bitewing x-rays every 5 months, up to a maximum of 2 sets per benefit year.

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

course of treatment.

Other services Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 5 months, up to a maximum of 2 per benefit year.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 5 months, up to a maximum of 2 sessions per benefit year.

For scaling, you are covered up to a combined maximum of 8 units of 15 minutes per benefit year.

Basic dental procedures

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

We will pay 80% of the eligible expenses for these procedures.

Fillings Amalgam, composite, acrylic or equivalent.

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

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

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

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

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

When coverage ends Dental Care coverage will end when the employee retires.

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

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

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges 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).

- charges related to implants, including surgery charges.
- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

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

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

- the end of the benefit year during which you incur the expenses, or
- the end of your Dental Care coverage.

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

Life Coverage

Insurer

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

General description of the coverage

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

Basic Life coverage for you

Amount

Your Life benefit is 2 times your annual basic earnings, rounded to the next higher $1,000. The maximum amount of coverage is $1,000,000.

Reduction

Your benefit will reduce to 50% of the above amount when you reach age 65.

Coverage ends

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

Optional Life coverage for you

Amount

You can choose coverage in units of $10,000. The maximum amount of coverage is $500,000.

Proof of good health

Proof of good health will be required when you request optional coverage and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility.

Coverage ends

Your coverage will end when you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Amount

You can choose Optional Life coverage for your spouse in units of $10,000 up to a maximum of $300,000.

Proof of good health Proof of good health for your spouse will be required when you request optional coverage for your spouse and any increase in that coverage, except for the first $30,000 if the request is made within 31 days of eligibility.

Coverage ends Optional coverage for your spouse will end when you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your children

Amount You can choose Optional Life coverage for your children in units of $5,000 up to a maximum of $20,000 per child.

Proof of good health Proof of good health for your children will be required when you request optional coverage for your children and any increase in that coverage, except if the request is made within 31 days of eligibility. If you do not request coverage within this time limit, you will have to provide proof of good health at your own expense.

Coverage ends Optional coverage for your children will end when you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

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

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

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

For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

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

Suicide

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

Coverage during total disability

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

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

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

Total disability must continue for at least an uninterrupted period of 6 months.

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

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

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience.

Converting Life coverage

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

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

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

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

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

When and how to make a claim

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

BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

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

SCOPE OF INSURANCE

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

ELIGIBILITY

All active employees of the policyholder.

INSURED PERSON'S BENEFITS

All active Employees are covered for a principal sum of two (2) times salary, rounded to the next higher $1,000; subject to a maximum of $1,000,000.

The principal sum reduces by 50% at age 65.

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

For Loss of	Percent of Benefit Amount
Life	100%
Both Arms and Both Legs	200%*
Speech and Hearing	100%

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

*Maximum of $1,000,000

If the employee has multiple losses as the result of one accident, the maximum amount payable shall not exceed 100% of the benefit amount, with the exception of Loss of and Loss of Use of Both Arms or Both Legs, Quadriplegia, Paraplegia or Hemiplegia. In no event will the maximum amount payable exceed 200%of the benefit amount.

- ***Brain Damage***

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

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

If the insured person dies within 365 days after the accident, then the benefit will pay a lump sum equal to the insured person's principal sum, less any benefit amount for brain damage already paid.

- ***Coma***

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

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

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

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

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

1) the insured person dies;
2) the insured person is no longer in a Coma; or
3) total payments equal 100% of the principal sum.

If the insured person dies within 365 days after the accident, then the benefit will pay a lump sum equal to the insured person's principal sum, less any benefit amount for coma already paid.

Maximum Payment for Multiple Losses and Multiple Benefits

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

TERMS AND CONDITIONS

Definitions:

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

"Loss" with reference to hand or foot means complete severance through or above the metacarpal phalangeal joint of at least four fingers or three fingers and a thumb or the ankle joint; with reference to arm or leg means complete severance through or above the elbow or

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

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

"Loss of Use" means the permanent and total inability of the specified body part to function provided the loss is continuous for 365 days.

Exposure & Disappearance

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

Accident includes unavoidable exposure to elements.

Beneficiary Designation

The insured person has the right to designate a beneficiary. All beneficiary designations must be:

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

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

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

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

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

1) the insured person's spouse;
2) in equal shares to the insured person's surviving children;
3) in equal shares to the insured person's surviving parents;
4) in equal shares to the insured person's surviving brothers and sisters;
5) the insured person's estate.

ADDITIONAL BENEFITS

- **Child Care Expense**

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

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

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

- **Education Expense**

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

1) is enrolled as a full-time student at an institution of higher learning on the date of the insured person's covered loss of life; or
2) subsequently enrols as a full-time student at an institution of higher learning within 2 years following the date of the insured person's covered loss of life; and
3) incurs education expense.

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

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

- **Family Travel Expense**

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

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

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

- **Funeral Expense**

This benefit will reimburse funeral expense up to $5,000 if accidental bodily injury causes the insured person's covered loss of life.

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

- **Home Alteration or Vehicle Modification**

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

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

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

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

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

- **Identification Expense**

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

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

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

- **In-Hospital**

This benefit will pay $75 after an elimination period of 3 days for each day the insured person is in-hospital, if an accidental bodily injury causes the insured person to suffer a covered loss which results in the insured person being in-hospital. The in-hospital benefit amount will not be paid for more than 31 days.

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

1) the insured person dies;
2) the insured person is no longer in-hospital; or
3) 30 days has elapsed.

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

- **Parent Care**

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

- **Psychological Therapy Expense**

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

1) the insured person; or
2) the insured person's dependent.

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

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

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

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

- **Rehabilitation Expense**

If an accidental bodily injury causes the insured person to suffer a covered loss which:

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

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

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

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

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

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

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

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

- **Repatriation**

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

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

- **Seat Belt & Occupant Protection Device**

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

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

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

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

In no event will the total payments for seat belt and occupant protection device exceed 20% of the principal sum up to a maximum of $50,000.

- **Spouse Employment Training Expense**

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

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

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

- **Vocational Training Expense**

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

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

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

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

TERMINATION OF INSURANCE

The insured person's insurance automatically terminates on the earliest of:

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

Upon termination, the insured person's insurance may continue, subject to the insured person's employer's employment policy, as follows:

1) if the insured person is on temporary lay-off, then insurance may continue for the full period of such lay-off but not for more than three hundred and sixty-five (365) days after the date on which such lay off begins;

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

Continuation of insurance is subject to the payment of premium.

Conversion Privilege

In the event the insured person's insurance under the policy ceases for any reason other than termination of the policy, the insured person is eligible to purchase an individual accident insurance policy.

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

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

for the individual accident insurance policy within thirty-one (31) days after the insured person's insurance ended.

The individual accident insurance policy will:

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

Waiver of Premium

We will waive a Primary Insured Person's premium due and continue insurance under this policy if a Primary Insured Person suffers Premium Waiver Disability provided that such Premium Waiver Disability:

1) begins while a Primary Insured Person is insured under this policy; and
2) exists continuously for a period of sixty (60) days.

As a condition precedent to this waiver of premium:

1) proof of Premium Waiver Disability must be furnished to Us, no later than twelve (12) months after the date on which such Premium Waiver Disability began; and
2) We shall have the right to examine the Primary Insured Person at any time during the first two (2) years after We receive proof of Premium Waiver Disability and no less frequently than annually thereafter.

When We receive satisfactory proof of Premium Waiver Disability, We will refund to the Policyholder, any premium paid during the period for the Premium Waiver Disability.

This waiver will cease on the first to occur of:

1) the date the Primary Insured Person ceases to be Premium Waiver Disabled;
2) the date the Primary Insured Person fails to submit required proof of Premium Waiver Disability; 3) the date the Primary Insured Person fails to submit to any physical examination;
4) the date the Primary Insured Person attains age sixty-five (65);
5) the date this policy ends; or 6) the date the Primary Insured Person dies.

EXCLUSIONS

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

Owned or Leased Aircraft

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

Pilot or Crew

- Loss caused by or resulting from, directly or indirectly, the insured person riding as a passenger in, entering, or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

Disease or Illness

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

Incarceration

- Loss caused by or resulting from, directly or indirectly any occurrence while the insured person is incarcerated after conviction.

Service in the Armed Forces

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

Suicide or Intentional Injury

- Loss caused by or resulting from, directly or indirectly, the insured person's suicide, attempted suicide or intentionally self-inflicted injury.

Trade Sanctions

- Loss when any trade or economic sanctions prohibit insurance of any accident, accidental bodily injury or loss; or there is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

War

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

This description is a summary of the principal features of the Plan, which is governed by the terms of the insurance contract with Chubb Insurance Company of Canada under policy 9906-72-81.

- .

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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).