

Securiguard Services Limited

Hourly employees

DRAFT

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Table of Contents

General Information	1
About this booklet.....	1
Eligibility.....	1
Who qualifies as your dependent.....	2
Enrolment.....	3
When coverage begins.....	3
Changes affecting your coverage.....	4
Updating your records.....	5
When coverage ends.....	5
Replacement coverage.....	6
Making claims.....	6
Proof of disability.....	6
Coordination of benefits.....	7
Medical examination.....	8
Recovering overpayments.....	8
Definitions.....	8
Extended Health Care (Medicare Supplement).....	10
General description of the coverage.....	10
Deductible.....	10
Prescription drugs.....	11
Hospital expenses in your province.....	12
Expenses out of your province.....	13
Medical services and equipment.....	16
Paramedical services.....	18
Contact lenses, eyeglasses or laser eye correction surgery.....	19
When coverage ends.....	20
Payments after coverage ends.....	20
What is not covered.....	20
When and how to make a claim.....	21
Emergency Travel Assistance.....	22
Dental Care.....	28
General description of the coverage.....	28
Deductible.....	29
Benefit year maximum.....	29
Restriction on payments.....	29

Predetermination	29
Preventive dental procedures	29
Basic dental procedures.....	30
Major dental procedures.....	31
When coverage ends.....	32
Payments after coverage ends.....	32
What is not covered	32
When and how to make a claim.....	33
Life Coverage	34
General description of the coverage.....	34
Basic Life coverage for you.....	34
Optional Life coverage for you.....	34
Optional Life coverage for your spouse.....	34
Who we will pay	35
Suicide	35
Coverage during total disability.....	35
Converting Life coverage.....	36
When and how to make a claim.....	37
Accidental Death and Dismemberment	38
General description of the coverage.....	38
Basic accidental coverage for you.....	38
Optional accidental coverage for you.....	38
Optional accidental coverage for your spouse.....	38
What we will pay	38
Limit on benefit amounts	40
Repatriation benefit	40
Rehabilitation program.....	41
Spouse occupational training benefit.....	41
Child education benefit	41
Family transportation benefit.....	42
Home/vehicle modification benefit	42
Seat belt benefit	42
Coverage during total disability.....	43
What is not covered	43
Converting coverage.....	44
When and how to make a claim.....	44

General Information

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 self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care

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

Eligibility

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

- you are a permanent employee.
- you are actively working for your employer at least 20 hours a week.

- you have completed the waiting period.

The waiting period for your group plan is 9 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 has been publicly represented as your spouse for at least the last 12 months, is an eligible dependent. You can only cover one spouse at a time.

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

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

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

- the child is incapable of financial self-support because of a

physical or mental disability, and

- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

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

Enrolment

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

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

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

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

When coverage begins

Your coverage begins on the later of the following dates:

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

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

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

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

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

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

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

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

Changes affecting your coverage

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

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

For a commissioned salesperson, any change in coverage resulting from a change in basic earnings will take effect on the following July 1. If the earnings change takes effect on July 1, then the change in coverage will take effect on that same day.

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.

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:

- 12 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 the spouse's Optional Life and Optional Accidental Death and Dismemberment.

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

No legal action may be brought by you more than one year after the date we must receive your claim forms or more than one year after we stop paying disability benefits.

Proof of disability

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

Coordination of benefits

of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to 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 including any bonus or overtime earned on a regular basis, but excluding any incentive pay.
- If you are a commissioned salesperson, basic earnings are your average earnings over the past 2 years, as reported on your T4 slips, including commissions. If employed less than 2 years, basic earnings are your average earnings since your date of hire, including commissions.
- Contract holder*** The contract holder is Securiguard Services Limited.
- 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)

General description of the coverage

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

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

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

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

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

The benefit year is from July 1, 2011 to December 31, 2011, and then from January 1 to December 31.

Deductible

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

The deductible is \$50 each benefit year for each person up to a maximum of \$100 per family.

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

For *Expenses out of your province* and *Contact lenses, eyeglasses or*

laser eye correction surgery, there is no deductible.

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

Prescription drugs

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

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- vaccines.
- colostomy supplies.
- varicose vein injections.

We will cover 70% of the cost of the above drugs and supplies after you pay the deductible.

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 not pay for the following, even when prescribed:

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.

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

Dispensing fee Eligible expenses for the dispensing fee are limited to \$8.60 for each prescription or refill, and are covered at 100%.

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 70% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

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

The deductible does not apply to emergency services and 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 provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

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

Emergency services excluded from coverage Any expenses related to the following emergency services are not covered:

- services that are not immediately required or which could

reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.

- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

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

All referred services must be:

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

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

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

applicable lifetime maximum.

***Referred services
outside Canada***

Expenses incurred for referred services outside Canada are subject to an annual maximum of \$50,000 per person or, if lower, any other applicable lifetime maximum.

**Medical services and
equipment**

We will cover 70% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of \$5,000 per person per benefit year.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
 - laboratory tests.

- ultrasounds.
- MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of \$500 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 \$50 in any 12 month period for a person under age 18 or in any 24 month period for any other person.
- contact lenses or intraocular lenses following a cataract surgery, up to a maximum of \$250 per person every 24 consecutive months.
- wigs following chemotherapy, up to a lifetime maximum of \$200 per person. Wigs do not require a doctor's order.
- glucometers (prescribed by a diabetologist or a specialist in internal medicine), oxygen & oxygen equipment, apnea monitor, Cystic fibrosis equipment, TENS machine (limited to a lifetime maximum of \$700 per person), stimulator (bone growth, muscle) & supplies, insulin pumps, inhalation appliance/device for drug administration and intermittent positive pressure breathing machines, up to a combined lifetime maximum of \$10,000 per person.
- 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, up to a lifetime maximum of \$1,500 per person.

- 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 – 2 brassieres per person every 24 months up to a maximum of \$200 per person.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- pressure gradient hose, up to a maximum of \$500 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 \$200 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 \$200 per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$700 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- plasma and blood transfusions.

Paramedical services

We will cover 70% of the costs after you pay the deductible, up to a maximum of \$500 per person per specialty in a benefit year for the paramedical specialists listed below:

- licensed psychologists or social workers.

- licensed massage therapists.
- licensed speech therapists.
- licensed physiotherapists.
- licensed naturopaths.
- licensed osteopaths or osteopathic practitioners.
- licensed chiropractors.
- licensed podiatrists or chiropodists.
- licensed kinesiologists or kinotherapists, or practitioners who are active members of a provincial kinesiology association approved by Sun Life. A doctor's referral is required.

For services of licensed acupuncturists, we will cover 70% of the costs after you pay the deductible, up to a maximum of \$100 per person in a benefit year:

For x-rays by licensed osteopaths or osteopathic practitioners, chiropractors and podiatrists or chiropodists, we will cover 70% of the cost after you pay the deductible, up to a maximum of \$40 per person in benefit year.

**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 \$100 per person every 24 months.

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

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

any kind.

When coverage ends Extended Health Care coverage will end when the employee retires or reaches age 70, whichever is earlier.

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

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

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

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

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

What is not covered We will not pay for the costs of:

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

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:

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

Emergency Travel Assistance

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, Europ Assistance USA, Inc. (*Europ Assistance*) can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Europ Assistance. If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances

where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Europ Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

mentally or physically handicapped.

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

Advances will not be made for requests of less than \$200. Requests in

excess of \$200 will be made in full up to a maximum of \$10,000.

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

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

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

Limits on Emergency Travel Assistance coverage

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

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

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.

- the refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

**Liability of Sun Life
or Europ Assistance**

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

Dental Care

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.

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

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

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

completed.

The benefit year is from July 1, 2011 to December 31, 2011, and then from January 1 to December 31.

Deductible

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

The deductible is \$50 each benefit year for each person, up to a maximum of \$100 per family.

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

Benefit year maximum

We will not pay more than \$1,000 per person for the first benefit year, and \$1,000 per person for each following benefit year.

Restriction on payments

If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum amount we will pay for all eligible expenses is \$250 per person for the first benefit year.

Predetermination

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

Preventive dental procedures

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

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

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.

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 after you pay the deductible.

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.

For scaling, you are covered up to a combined maximum of 12 units of 15 minutes per benefit year.

Post-operative visits, up to 4 visits in a benefit year.

Curettage, once every 60 months.

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

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

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

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

Repair Repair of bridges or dentures.

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

Prosthodontics Construction and insertion of bridges or standard dentures, after the person has been covered continuously under this provision for a period of 12 months. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

- it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.

- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

When coverage ends Dental Care coverage will end when the employee retires or reaches age 70, whichever is earlier.

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

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

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension

corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).

- charges related to the temporomandibular joint (TMJ) treatment.
- 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:

- 12 months after the end of the benefit year during which you incur the expenses, or
- 90 days after the end of your Dental Care coverage, whichever is earlier.

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

Life Coverage

General description of the coverage Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.

Basic Life coverage for you

Amount Your Life benefit is \$15,000.

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 or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount You can choose coverage in units of \$10,000. The maximum amount of coverage is \$200,000.

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 \$200,000.

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*.

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.

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.

Suicide

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

Living Benefits Loan Program

If you are terminally ill with a life expectancy of 24 months or less, you may apply for a commercial loan under the Sun Life Living Benefits Loan Program. Under this program, you may receive an advance of up to 50% of your Basic Life coverage, to a maximum of \$100,000.

If you are within 5 years of a scheduled reduction of your Basic Life coverage, the advance you may receive cannot exceed 50% of the lowest reduced amount of your Basic Life coverage. If you are within 5 years of the termination of your Basic Life coverage, you may not apply for a commercial loan under the Sun Life Living Benefits Loan Program. This program is subject to other restrictions. Please contact your employer for details.

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.

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

**When and how to
make a claim**

can be converted. Please contact your employer for details.

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

Accidental Death and Dismemberment

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

Basic accidental coverage for you

Amount Your Basic Accidental Death and Dismemberment coverage is equal to the amount of Basic Life coverage.

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 accidental coverage for you

Amount You can choose coverage in units of \$10,000. The minimum amount of coverage is \$20,000. The maximum amount of coverage is \$200,000.

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 accidental coverage for your spouse

Amount You can choose Optional Accidental Death and Dismemberment coverage for your spouse in units of \$10,000. The minimum amount of coverage is \$20,000. The maximum amount of coverage is \$200,000.

Coverage ends 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*.

What we will pay

We will pay for this benefit if you or your spouse:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you or your spouse are still alive.
- are in an accident or exposed to the elements and, as a direct result, you or your spouse suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages we use to determine the payment.

TABLE OF LOSSES

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

Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. We will not pay more than 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay a maximum of 200%.

Loss of an arm means that it was severed at or above the elbow. Loss of a hand means that it was severed at or above the wrist. Loss of a leg means that it was severed at or above the knee. Loss of a foot means that it was severed at or above the ankle. Loss of a thumb, finger or toe means that it was severed at or above the first joint from the hand or foot. Loss of sight, speech or hearing must be total and permanent.

Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

Limit on benefit amounts

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

If the total amount of benefits payable for the accident is more than \$3,000,000, then we will pay for each person a percentage of the \$3,000,000 that is equal to the percentage the person would have received of the total payable.

Repatriation benefit

If you die as a direct result of an accident 100 kilometres or more from home, we will pay up to \$10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.

Rehabilitation program

If you suffer a loss, other than a loss of life, we will pay up to \$10,000 of your rehabilitation expenses. We will only pay for the usual and reasonable expenses connected with a rehabilitation program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the rehabilitation program and the expenses must be incurred within 3 years of the accident and while you are covered for this benefit. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the rehabilitation program will be based on the likelihood that it will be successful. The rehabilitation will be made up of training required, because of the loss, to prepare you for a new occupation.

Spouse occupational training benefit

If you die as a direct result of an accident, we will pay up to \$5,000 to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the expenses and all expenses must be incurred within 3 years of the date of the accident. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the training program will be based on the likelihood that it will be successful.

Child education benefit

If you die as a direct result of an accident, we will pay for a dependent child's tuition fees in a post-secondary school. We will pay the child

5% of the amount of coverage up to \$5,000, each year up to a maximum of 4 years. The child must enrol as a full-time student within one year of your death.

We will only pay for the usual and reasonable tuition expenses. This does not include ordinary living expenses such as room, board, travelling or clothing. This also does not include education expenses incurred prior to your death.

Family transportation benefit

If you suffer a loss as a direct result of an accident and are hospitalized at least 150 kilometres from home, we will pay up to \$5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister.

We will only pay for the usual and reasonable travel expenses. We will pay for car travel at a rate of \$0.20 per kilometre. Transportation must be by the most direct route to and from the hospital. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Home/vehicle modification benefit

If you suffer a loss as a direct result of an accident and are confined in a wheelchair, we will pay up to \$10,000 for:

- one time modifications to your principal residence to make it wheelchair accessible and habitable by you, and
- one time modifications to a motor vehicle used by you to make the vehicle accessible or driveable for you.

We must approve the expenses and all expenses must be incurred within one year of the date of the accident.

We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Seat belt benefit

If you suffer a loss while you are a passenger or driver of a private passenger type motor vehicle and your seat belt is properly fastened, we will pay 10% of the amount of coverage. We will require

verification of actual use of seat belt, either as part of the official report of accident or as certified by the police. You must hold a current and valid driver's licence if operating the vehicle.

Coverage during total disability

If you become totally disabled while covered and premiums are no longer payable for Life coverage, this Accidental Death and Dismemberment coverage will continue without the payment of premiums, but not beyond age 65, for as long as premiums are not payable for your Life coverage.

Any amount of coverage continued is subject to the terms of this group plan when total disability began.

What is not covered

We will not pay for losses that are the result of:

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

Converting coverage If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy.

This applies to your spouse's coverage as well.

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

For any loss other than death, the claim must be received by Sun Life within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

**This group plan arranged by:
Signet Financial Group Ltd.
Tel. No. 604-682-9505
Fax No. 604-681-0059**