your group benefits

Contract Number: 103039, 150939, 151039, 152260,100011489, 100011496, 100013286 and EAP
Effective: January 1, 2025
Issued: December 17, 2024

Schlumberger Canada Limited

All Active Employees

slb

Sun Life Financial

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How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-866-896-6976.

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

Plan Member Services

Download the my Sun Life Mobile App!

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

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

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

Access to mysunlife website

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

Prior Authorization Program

For the form:

- visit our website at www.mysunlife.ca/priorauthorization
- call a Sun Life Financial Customer Care representative toll-free at 1-866-896-6976

For the list of drugs:

- visit our website at www.mysunlife.ca/priorauthorization

Your Drug Card

Provided by your employer or online at www.mysunlife.ca.

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

Your Travel Card

Provided by your employer or online at www.mysunlife.ca.

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

Need to contact Sun Life's Emergency Travel Assistance provider?

In the USA and Canada, call: 1-800-511-4610.

All other inquiries

Contact your employer at the Benefits Central at www.slb-benefits.ca or call 1-866-557-5222.

Benefit Summary

The information contained in this summary applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Basic and Voluntary A.D&D and Employee and Family Assistance Program benefits described later in this booklet are not insured or administered by Sun Life. The Canada Short Term Disability benefit described later in this booklet is not insured by Sun Life.

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

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Waiting period	None
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care - Contract Number 150939

	Option 1	Option 2	Option 3
Benefit year	January 1 to December 31		
Deductible	None	None	None
Reimbursement level			
Drug card plan	Included	Included	Included
Prescription drugs	60%	90%	100%
	Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation* We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist: • 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 • products to help a person quit smoking that legally require a prescription • vaccines • intrauterine devices (IUDs) and diaphragms • colostomy supplies • varicose vein injections		

	Option 1	Option 2	Option 3
	• drugs for the treatment of sexual dysfunction, up to a lifetime maximum of $1,000 per person • anti-obesity drugs if approved by us. To assess the medical necessity, we will require the covered person and the attending doctor to complete and submit a Special authorization application for drug products for treatment of obesity form.		
Drugs for the treatment of infertility	Not covered	Lifetime maximum of $5,000 per person	Lifetime maximum of $10,000 per person
Drugs and treatments that are not covered	There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.		
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.		
Dispensing fee	Not covered, unless dispensed through Costco pharmacy and are covered at 100%		
Drug substitution limit	We will not cover charges above the lowest priced equivalent drug unless we specifically approve them. To assess the medical necessity of a higher priced drug, Sun Life will require the covered person and the attending doctor to complete and submit an Exception Form.		
In-province hospital	60%, of the difference between the cost of a ward and a semi-private room	90%, of the difference between the cost of a ward and a semi-private room	100%, of the difference between the cost of a ward and a private room
Convalescent hospital	60%, of the difference between the cost of a ward and a semi-private room	90%, of the difference between the cost of a ward and a semi-private room	100%, of the difference between the cost of a ward and a semi-private room
Out-of-province emergency services	100% Emergency Travel Assistance included Maximum of 90 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Maximum of 90 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services	100% Emergency Travel Assistance included Maximum of 90 days per trip Lifetime maximum of $3,000,000 per person for out-of-Canada services
Out-of-province referred services	80%	80%	80%
Medical services and equipment	60%	90%	100%
Gender affirmation procedures	Not covered	90%, up to a lifetime maximum of $10,000 per person	100%, up to a lifetime maximum of $20,000 per person

	Option 1	Option 2	Option 3
Paramedical services			
Psychological services	60%, up to a combined maximum of $1,000 per person for psychologists, social workers, clinical counsellors, psychiatrists, psychotherapists, psychoanalysts, mental health counsellors, marriage or family therapists	90%, up to a combined maximum of $1,500 per person for psychologists, social workers, clinical counsellors, psychiatrists, psychotherapists, psychoanalysts, mental health counsellors, marriage or family therapists	100%, up to a combined maximum of $2,500 per person for psychologists, social workers, clinical counsellors, psychiatrists, psychotherapists, psychoanalysts, mental health counsellors, marriage or family therapists
Physical services	60%, up to a maximum of $500 per person per specialty in a benefit year but no more than an overall maximum of $1,000 per person per benefit year for all qualified paramedical practitioners combined listed below: • massage therapists or Shiatsu therapists • physiotherapists • occupational therapists • athletic therapists • osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year • chiropractors, including a maximum of one x-ray examination each benefit year • podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year • kinesiologists/ kinotherapists	90%, up to a maximum of $750 per person per specialty in a benefit year but no more than an overall maximum of $1,500 per person per benefit year for all qualified paramedical practitioners combined listed below: • massage therapists or Shiatsu therapists • physiotherapists • occupational therapists • athletic therapists • osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year • chiropractors, including a maximum of one x-ray examination each benefit year • podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year • kinesiologists/ kinotherapists	100%, up to a maximum of $1,250 per person per specialty in a benefit year but no more than an overall maximum of $2,500 per person per benefit year for all qualified paramedical practitioners combined listed below: • massage therapists or Shiatsu therapists • physiotherapists • occupational therapists • athletic therapists • osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year • chiropractors, including a maximum of one x-ray examination each benefit year • podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year • kinesiologists/ kinotherapists

	Option 1	Option 2	Option 3
Holistic services	60%, up to a maximum of $500 per person per specialty in a benefit year but no more than an overall maximum of $1,000 per person per benefit year for all qualified paramedical practitioners combined listed below: • speech therapists • naturopaths • acupuncturists • audiologists • dieticians • homeopaths	90%, up to a maximum of $750 per person per specialty in a benefit year but no more than an overall maximum of $1,500 per person per benefit year for all qualified paramedical practitioners combined listed below: • speech therapists • naturopaths • acupuncturists • audiologists • dieticians • homeopaths	100%, up to a maximum of $1,250 per person per specialty in a benefit year but no more than an overall maximum of $2,500 per person per benefit year for all qualified paramedical practitioners combined listed below: • speech therapists • naturopaths • acupuncturists • audiologists • dieticians • homeopaths
Vision care	Contact lenses, eyeglasses or laser eye correction surgery – not covered	Contact lenses, eyeglasses or laser eye correction surgery – 90% up to a maximum of $300 per person in any 24 month period	Contact lenses, eyeglasses or laser eye correction surgery – 100% up to a maximum of $500 per person in any 24 month period
Services of an ophthalmologist or licensed optometrist (eye examinations)	Eye examinations are limited to one examination per person in any 24 month period	Eye examinations are limited to one examination per person in any 24 month period	Eye examinations are limited to one examination per person in any 24 month period
Maximum benefit	Unlimited	Unlimited	Unlimited
Lock-in period	None	None	None
Changes in options	You can change your option during the annual enrolment period or within 30 days of a life event change.		
Lumino Health Virtual Care services	Included		
Termination	When you retire. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.		
At retirement	For more information about coverage after retirement, please contact your employer		

Dental Care - Contract Number 150939

	Option 1	Option 2	Option 3
Benefit year	January 1 to December 31		
Deductible	None	None	None
Fee guide	The current fee guide for general practitioners in the province where the employee lives, regardless of where the treatment is received	The current fee guide for general practitioners in the province where the employee lives, regardless of where the treatment is received	The current fee guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. For Preventive and Basic expenses the fee guide is adjusted by 20%
Reimbursement level			
Preventive procedures	60%	90%	100%
Basic procedures	60%	90%	100%
Major procedures	50%	70%	80%
Orthodontic procedures	Not covered	50%	50%
Maximum benefit			
Benefit year maximum	$1,500 per person	$2,500 per person A separate lifetime maximum (below) applies to Orthodontic expenses	$3,500 per person A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime maximum	Not Applicable	Orthodontic procedures – $2,500 per person	Orthodontic procedures – $3,500 per person
Lock-in period	None	None	2 years
Changes in options	You can change your option during the annual enrolment period or within 30 days of a life event change.		
Termination	When you retire. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.		
At retirement	For more information about coverage after retirement, please contact your employer		

Health Spending Account - Contract Number 150939

Benefit year	January 1 to December 31
Credits	Remaining Flex credits at the beginning of each benefit year
Eligible expenses	Expenses that are considered eligible medical, hospital and dental expenses under the Income Tax Act (Canada) and are not paid, or not paid in full, under your group plan, your spouse's/partner's plan or any government-sponsored plan
Termination	When you retire. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.
At retirement	For more information about coverage after retirement, please contact your employer

Personal Spending Account - Contract Number 151039

Benefit year	January 1 to December 31
Credits	Remaining Flex credits at the beginning of each benefit year
Termination	When you retire. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Wellness Personal Spending Account - Contract Number 152260

Benefit year	January 1 to December 31
Credits	$450 at the beginning of each benefit year
Termination	When you retire. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Long-Term Disability – Contract Number 103039

	Option 1	**Option 2**	**Option 3**
Maximum amount	45% of the first $5,500 of your monthly eligible compensation (rounded to the nearest $1), plus 32% of the balance of your monthly eligible compensation, up to a maximum benefit of $15,000	55% of the first $4,000 of your monthly eligible compensation (rounded to the nearest $1), plus 42% of the balance of your monthly eligible compensation, up to a maximum benefit of $15,000	65% of the first $2,000 of your monthly eligible compensation (rounded to the nearest $1), plus 53% of the next $5,000, plus 45% of the balance of your monthly eligible compensation, if any, up to a maximum benefit of $15,000
	The maximum amount may be reduced by benefits and payments provided from other sources as described in *the Long-Term Disability* section of this booklet		

	Option 1	Option 2	Option 3
Cost of living adjustment	Not applicable	Not applicable	Your Long-Term Disability payment will be increased in January 1 of each year to reflect the average increase, if any, in the Canadian Consumer Price Index over the 12 month period ending 3 months prior to the date of any adjustment. Any percentage increase to your benefit payment cannot exceed 3%. In the event of deflation, we will not decrease your benefit payment
Elimination period	12 months		
Maximum benefit period	The period ending on the last day of the month in which you reach age 65 Benefits may also end on an earlier date as specified in the *Long-Term Disability* section of this booklet		
Lock-in period	1 year	1 year	1 year
Change in options	Subject to the *lock-in period* indicated above, you can change your option during the *annual enrolment period* or within 30 days of a *life event change*. Proof of good health is required when increasing coverage to a higher Option (Option 1 to Option 2 or Option 2 to Option 3). Proof of good health is not required when making a change due to a *life event change*.		
Termination	The day you reach age 65 less the elimination period or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.		
Tax status	Your employer has indicated that this disability plan is an employee-pay-all plan, which means all required premium is paid by the employees covered under the plan. Therefore, the benefit payments are not taxable income.		

Life - Contract Number 103039

Employee Basic Life

Amount	2 times your annual eligible compensation rounded to the next higher $1,000 Maximum – $1,000,000
Reduction	Coverage is reduced to 50% of the above amount when you reach age 65 If you continue, or begin, to work after having reached age 65, we calculate the amount for which you would have been eligible if you had not already reached age 65, then, we apply the above reduction clause to calculate the amount for which you are eligible.
Termination	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

At retirement	For more information about coverage after retirement, please contact your employer

Employee Optional Life

Amount	You can choose coverage in units of $25,000 Maximum – $500,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Basic Dependent Life

Amount	Spouse/Partner – $10,000 Child – $5,000
Termination	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Spouse/Partner Optional Life

Amount	You can choose coverage in units of $25,000 Maximum – $500,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, or when your spouse/partner reaches age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Child Optional Life

Amount	You can choose coverage in units of $5,000 per child Maximum – $25,000
Termination	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Making Claims

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

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

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

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

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

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

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Ask your employer for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Extended Health Care coverage.
Emergency Travel Assistance	Contact Sun Life's Emergency Travel Assistance provider to notify them that a medical emergency exists.	**Having expenses reimbursed:** To have services or supplies reimbursed that either you or another covered person have paid for, proof of the expenses must be provided to us within 30 days of the person's return to the province where the person lives. Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.
Dental Care	Ask your employer for the form to complete, or get the form on our website. The dentist will have to complete a section of the form. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Dental Care coverage. If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information. For orthodontic procedures, a treatment plan will need to be submitted to us.

Health Spending Account	Ask your employer for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to 90 days after the earlier of the following dates: • the end of the benefit year during which the expense is incurred, or • the end of your Health Spending Account coverage.
Personal Spending Account	Ask your employer for the form to complete, or get the form on our website.	Up to 90 days after the earlier of the following dates: • the end of the benefit year during which the expense is incurred, or • the end of your Personal Spending Account coverage.
Wellness Personal Spending Account	Ask your employer for the form to complete, or get the form on our website.	Up to 90 days after the earlier of the following dates: • the end of the benefit year during which the expense is incurred, or • the end of your Wellness Personal Spending Account coverage
Long-Term Disability	We will use the claim forms that were completed when you submitted your claim for Short-Term Disability.	If your Long-Term Disability coverage terminates, you must advise us of the claim within 30 days of the date the coverage terminates. We will assess the claim and send you or your employer a letter outlining our decision. From time to time, we can require that you provide us with proof of your continued total disability. We must be provided with this information within 90 days of the request.
Life coverage	Ask your employer to provide the claim forms.	We must receive the claim form as soon as possible after the death occurred. **For coverage during total disability:** We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

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. The Basic and Voluntary A.D&D and Employee and Family Assistance Program benefits described later in this booklet are not insured or administered by Sun Life. The Canada Short Term Disability benefit described later in this booklet is not insured by Sun Life.

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 contracts with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies, as described below.

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

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

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

Your group benefits

The contract holder, Schlumberger Canada Limited, has entered into an Administrative Services Contract with Sun Life for the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Health Spending Account

The contract holder self-insures the benefits listed above. This means the contract holder has the sole legal and financial liability for these benefits and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

In addition, the contract holder has established a Personal Spending Account and Wellness Personal Spending Account and entered into a Personal Spending Account Services Contract with Sun Life. The contract holder has the sole legal and financial liability for the Personal Spending Account and Wellness Personal Spending Account and Sun Life only acts as administrator.

All other benefits are insured by Sun Life.

Who is eligible to receive benefits?

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

- you are a permanent employee working in Canada.
- you are actively working for your employer at least 20 hours a week.
- you have completed the waiting period indicated in the Benefit Summary.

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

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

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

Who qualifies as your dependent	Your dependent must be: • your spouse/partner or your child, and • residing in Canada or the United States. **Your spouse/partner** qualifies as your dependent if they are your spouse/partner in one of the following ways: • by marriage. • under any other formal union recognized by law. • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least the last 6 months. For employees residing in Québec, there is no minimum cohabitation period for common-law spouses/partners if a child is born (or adopted) out of the relationship. You can only cover one spouse/partner at a time. **Your children and your spouse's/partner's children** (other than foster children) are eligible dependents if they are under age 21 and do not have a spouse/partner. A child who is a full-time student under age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse/partner. **If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse/partner. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**
How to enrol	*For you* – You must provide the proper enrolment information to Sun Life through your employer. *For a dependent* – You must ask for dependent coverage. As part of the enrolment process, for Extended Health Care, Dental Care and Long-Term Disability, you must elect one of the options of coverage described in the Benefit Summary. If you do not make an election within 31 days of the date you become eligible for coverage, you will be covered for: • Extended Health Care – Option 1 • Dental Care – Option 1 • Long-Term Disability – Option 1 If you or your dependents already have similar Dental Care coverage under this or another plan – You may refuse this coverage under this plan. You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health. • Employee Optional Life • Spouse/Partner Optional Life • Child Optional Life

When coverage begins	Your coverage begins on the date you become eligible for coverage. If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work. A dependent's coverage begins **on the later of** the following dates: • the date your coverage begins. • the date you first have a dependent. If you are not actively working on the date Optional Life coverage for your spouse/partner or children would normally begin, then that coverage will not begin until you return to active work with your employer.
Changes affecting your coverage	You may change your election of coverage during the annual enrolment period, subject to any lock-in periods described in the Benefit Summary. You may also change your election of coverage within 30 days of a life event change. Changes elected during the annual enrolment period take effect on the following January 1st. Changes elected within 30 days of a life event change take effect on the date of the life event change. If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health. If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer: • change of dependents. • change of name. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-866-896-6976.
When coverage ends	As an employee, your coverage will end on the earlier of the following dates: • the date your employment ends for any reason other than retirement on pension. • the date you are no longer actively working. • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends.

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

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

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

If you die while covered by this plan

Coverage for your dependents will continue, without anyone paying further 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 your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

For Extended Health Care and Dental Care, your dependents will continue to be covered for the option of coverage in effect on the date of your death.

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

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

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

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

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, the maximum amount that you can receive from all plans is:

- 100% of the total actual expenses, for Dental Care.
- 100% of the total eligible expenses, for Extended Health Care.

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

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

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

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

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

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.
Annual enrolment period	The period designated by your employer immediately prior to January 1st of each year.
Appropriate treatment	Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.
Eligible compensation	For employees with more than one year of service, eligible compensation is defined as the greater of the last full year of admissible compensation at Annual Enrollment, or this year's base salary. For employees with less than one year of service, your eligible compensation is your base salary only. Admissible compensation may include base pay, overtime, bonuses, commissions and geographical coefficients.
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.
Life event change	Life event changes include: • marriage or any other formal union recognized by law, or common-law, • birth or adoption of a child, • divorce or legal separation, • loss of spouse's/partner's benefit coverage, • gain of spouse's/partner's benefit coverage, or • death of a dependent.
Lock-in period	The minimum time that you must remain with your chosen option.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Extended Health 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 Extended Health Care benefits.

Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

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

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

Reasonable and customary charges mean:

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

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

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* outlined in the Benefit Summary.

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor. However, there are additional limits that apply to opioids (see *Opioid Management Solution program – drug supply limits* for details).
What is not covered	We will not pay for the following, even when prescribed: • infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments. • the cost of giving injections, serums and vaccines. • proteins and food or dietary supplements. • hair growth stimulants. • drugs that are used for cosmetic purposes. • natural health products, whether or not they have a Natural Product Number (NPN). • drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
Drug evaluation	The following drugs will be evaluated and must be approved by us to be eligible for coverage: • drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017. • drugs covered under this plan and subject to a significant increase in cost. Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval. We will assess the eligibility of the drug based on factors such as: • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • availability of other drugs treating the same or similar condition(s). • plan sustainability.
Prior authorization program	The prior authorization (PA) program applies to a limited number of drugs, where you must get approval in advance for coverage under the program. In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form. You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as: • Health Canada Product Monograph. • recognized clinical guidelines. • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • your response to preferred drug therapy. If not, your claim will be declined. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.

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.
Opioid Management Solution program – drug supply limits	The Opioid Management Solution program promotes the safer use of prescribed narcotic drugs. For persons residing outside of Québec, if we have not reimbursed an opioid expense for a covered person within 180 days of an opioid claim, coverage will be limited to a 7 day supply of short-acting opioids. In the absence of medical necessity, we will not cover expenses in excess of the above limits. To assess medical necessity, we will require the covered person and the attending doctor to complete and submit an exception form.

Hospital expenses in your province

Hospital	We will cover the cost of room and board in a hospital in the province where you live, as indicated in the Benefit Summary. 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.

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

Expenses out of your province

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, the reimbursement level is indicated in the Benefit Summary.** 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
Emergency services	We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. 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 treatment program that existed before they left their home province. *Emergency* means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. **Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away. Sun Life's ETA provider must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them. **If Sun Life's ETA provider does not hear from you first, before** you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency. In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. An emergency ends when Sun Life's ETA provider, based on available medical evidence, deems you 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. 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. However, if referred services are not available in Canada, they may be obtained outside of Canada.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private duty nurse	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor 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 cannot perform the duties	$25,000 per person, per lifetime

Covered expenses	Details	Payment limits
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor • ultrasounds • medical imaging services, including MRIs and CT scans	For all medical imaging services combined, $1,000 per person per benefit year
Dental services following an accident	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 You must receive these services within 12 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the employee lives
Contact lenses or intraocular lenses	After cataract surgery	One lens per eye, per lifetime
Wigs	After chemotherapy	$300 per person, per benefit year

Covered expenses	Details	Payment limits
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription 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, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses or crutches		
Splints or braces	Must be prescribed by a doctor	
Breast prostheses	Required as a result of surgery	2 prostheses per person in any 12 month period
Surgical brassieres	Required as a result of surgery	2 brassieres per person per benefit year
Artificial limbs and eyes		
Myoelectric arms		$10,000 per prostheses
Stump socks		5 pairs per person per benefit year
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	$250 per person per benefit year
Custom-made orthotics for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	Combined maximum of $600 per benefit year for a person under age 21 or $600 over a period of 3 benefit years for any other person
Hearing aids		$5,000 per person over 5 benefit years Repairs are included in this maximum
Oxygen		
Blood glucose monitors		One monitor per person over 4 benefit years
Continuous Glucose Monitor (CGM), including receivers, transmitters, and sensors	Only for persons diagnosed with Type 1 or Type 2 diabetes requiring insulin use You must provide us with a doctor's note confirming both the diagnosis and insulin use	Combined maximum of $4,000 per person per benefit year
Insulin pumps	Must be prescribed by a doctor	
TENS machines	Must be prescribed by a doctor	$700 per person, per lifetime
Mechanical or hydraulic lifts	Must be prescribed by a doctor	One lift up to a maximum of $2,000 per person over 5 benefit years

Covered expenses	Details	Payment limits
Outdoor wheelchair ramps	Must be prescribed by a doctor	$2,000 per person, per lifetime
Extremity pumps	Must be prescribed by a doctor	$1,500 per person, per lifetime
Fertility treatments	Must be prescribed by a doctor	*Option 2* – 90%, up to a lifetime maximum of $10,000 per person *Option 3* – 100%, up to a lifetime maximum of $20,000 per person

Gender affirmation procedures

Gender affirmation procedures

We will cover, up to the reimbursement level indicated in the Benefit Summary, the costs of the following gender affirmation procedures, 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.
- hysterectomy.
- vaginectomy.
- salpingo-oophorectomy.
- chest contouring/chest masculinization, other than liposuction/lipofilling.
- implantation of penile and/or testicular prostheses.

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.

Covered expenses	Details	Payment limits
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary
Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us. *Qualified* paramedical practitioners must: • belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us, • be licensed or registered, as required by the applicable provincial regulatory body, • have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered, • maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association, • produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and • not engage in administrative practices unacceptable to us. This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.		
Vision care		
Contact lenses, eyeglasses, services of an ophthalmologist or licensed optometrist (eye examinations) or laser eye correction surgery	An ophthalmologist or licensed optometrist must have prescribed contact lenses or eyeglasses You must have received the above from an ophthalmologist, licensed optometrist or optician We will only cover laser eye correction surgery that an ophthalmologist has performed	Up to the reimbursement level indicated in the Benefit Summary 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

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

Payments after coverage ends

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

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

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

- the accident occurred while you were covered, and
- you have the procedure within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

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

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

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

Integrating this plan with government programs

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

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

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

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.

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. We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

The emergency services excluded from coverage, and all other conditions including maximums, limitations and exclusions that apply to your Extended Health Care coverage also apply to Medi-Passport.

Bring your Travel card with you! There you will find telephone numbers and the information you'll need to confirm your coverage and get help.

Getting help	**Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away. **If Sun Life's ETA provider does not hear from you first, before** you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency. In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. 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 (sent home); or • **for a child** if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified person to go home with the child as their attendant. 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 hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.

Returning you home (repatriation)	If you die while out of the province where you live, Sun Life's ETA provider will pay up to $5,000 to do the following: • arrange for all necessary government authorizations. • arrange for the return of your remains in an approved container.
Returning your vehicle	Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 to return 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 doing so.
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 direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
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.
Reimbursement of expenses	If you obtain confirmation from Sun Life's ETA provider that you are covered and a medical emergency exists, Sun Life will reimburse you for services and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Sun Life's ETA provider. Sun Life's ETA provider's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-866-896-6976. Sun Life's ETA provider will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Sun Life's ETA provider before your claim can be processed.
Coordination of coverage	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.
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.

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 you leave on your trip. 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, terrorism or an act of God. • a 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 and customary charges**. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. When a fee guide is not published for a given year, the term fee guide may also mean an adjusted fee guide established by Sun Life.

Reasonable and customary charges mean:

- charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined by Sun Life.

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

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

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

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

If you receive any temporary dental service	It will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the reasonable and customary charge for the final dental service.
Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incurred the expense. The benefit year is indicated in the Benefit Summary. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed, except for orthodontic procedures where an expense is incurred for each appointment. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary**.
Maximum benefit	Maximums are indicated in the Benefit Summary.

Getting an estimate before you have certain procedures	For any major treatment or any procedure that will cost more than $500, we suggest that you send us an estimate before the work is done. Here's what to expect: • you will send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. • both you and the dentist will have to complete parts of the claim form. • we will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Your dental services at a glance

Covered expenses	Details / Payment limits
Preventive dental procedures – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.	
Oral examinations	• 1 complete examination every 36 months. • 2 recall examinations every 12 months. • emergency or specific examinations.
X-rays	• 1 complete series of x-rays or 1 panorex every 36 months. • 2 sets of bitewing x-rays every 12 months. • x-rays to diagnose a symptom or examine progress of a certain course of treatment.
Other services	• required consultations between two dentists. • polishing (cleaning of teeth) and topical fluoride treatment twice every 12 months. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth. • providing space maintainers for missing primary teeth. • pit and fissure sealants. Only children under age 19 are covered for this procedure.
Anaesthesia	• anaesthesia in conjunction with a Preventive procedure covered under this plan.
Basic dental procedures – Your dental benefits include the following procedures used to treat basic dental problems.	
Fillings	• amalgam (silver) and composite or acrylic (white), or equivalent.
Extraction of teeth	• removing teeth, except 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. A retreatment is an eligible expense only in the case of a failed procedure and must be separated from the failed procedure by at least 18 months and is limited to a maximum of 1 retreatment in a person's lifetime.

Periodontics	• treating disease of the gum and other supporting tissue. • scaling and root planing, up to a combined maximum of 16 units of 15 minutes per benefit year. • occlusal equilibration, up to a maximum of 4 units of 15 minutes per benefit year.
Oral surgery	• surgery, other than the removal of impacted teeth (*Preventive dental procedures*) and implant related surgery (*Major dental procedures*).
Rebase or reline	• rebase or reline of an existing partial or complete denture, once every 36 months.
Anaesthesia	• anaesthesia in conjunction with a Basic procedure covered under this plan.
Major dental procedures – Your dental benefits include the following procedures used to treat major dental problems.	
Major restorations	• inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).
Repair of bridges	• repair of bridges.
Repair of dentures	• repair of dentures.
Prosthodontics	Construction and insertion of bridges or standard dentures. We do not consider charges for a replacement bridge or replacement standard denture an eligible expense during the 5 year period after a previous bridge or standard denture is constructed or inserted, unless either 1. or 2. below is true: 1. it is needed to replace a bridge or standard denture which has caused temporomandibular joint (TMJ) disturbances and which cannot be economically modified to correct the condition. 2. it is needed to replace a transitional denture which was inserted shortly after teeth were extracted, where the dentist cannot economically get it to the final shape needed.
Implants	• implants, including surgery charges, subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant.
Anaesthesia	• anaesthesia in conjunction with a Major procedure covered under this plan.
Orthodontic procedures – Your dental benefits include the following procedures used to treat misaligned or crooked teeth.	
Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces	The following orthodontic procedures are covered: • interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*). • comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.
Anaesthesia	• anaesthesia in conjunction with a Orthodontic procedure covered under this plan.

When coverage ends

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

Payments after coverage ends

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

- the accident occurred while you were covered, and
- you have the procedure within 6 months after the date of the accident.

What is not covered

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

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

We will not pay for:

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

Health Spending Account

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.

Your Health Spending Account coverage provides reimbursement to you for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependent is your spouse/partner, your children or any other person whom you may claim as dependents under the Income Tax Act (Canada). For example, this could include members of your extended family, such as your parents, grandparents or grandchildren. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care or Dental Care benefits.

The benefit year is indicated in the Benefit Summary.

How your Health Spending Account works	Your Health Spending Account works like an expense account. Your employer will allocate credits to your account in the manner described under *Credits* in the Benefit Summary. Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Health Spending Account.
Balance carry-forward	This plan is set up with a ***balance carry-forward*** feature. This means that you may be reimbursed for eligible expenses incurred in a benefit year using credits received during that benefit year, as well as any unused credits that have been carried forward from the previous benefit year. In other words, any credits remaining in your Health Spending Account at the end of one benefit year will be carried forward and may be used to reimburse you for eligible expenses incurred in the following benefit year. Credits that are carried forward from one benefit year to the next will be lost at the end of the second benefit year if you have not used them by then. Carried forward credits are always used before new credits are used. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim. There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not paid, or not paid in full, under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Eligible expenses

You can use your Health Spending Account to cover medical, hospital and dental expenses that are eligible under the Income Tax Act (Canada) and are not paid, or not paid in full, under your group plan, your spouse's/partner's plan or any government-sponsored plan.

Eligible expenses include but are not limited to the items listed below:

- portion of expenses not covered by a health or dental benefits plan such as deductibles, coinsurances or amounts over plan maximums.
- premiums for health or dental benefits.
- drugs or other preparations when prescribed by a qualified medical practitioner or dentist and dispensed by a pharmacist.
- services performed by a qualified medical or dental practitioner.
- payments to a hospital or another facility such as nursing home, special school, institution or other place for care and training of a mentally or physically impaired individual.
- remuneration of a full-time attendant, or for the cost of full-time care in a nursing home of a mentally or physically impaired individual. Condition must be certified by a qualified medical practitioner.
- emergency services or referred services outside the person's province of residence.
- eyeglasses, contact lenses or laser eye correction surgery when prescribed by a qualified medical practitioner.
- medical devices, supplies or equipment when prescribed by a qualified medical practitioner.
- diagnostic screening, laboratory or radiological procedures when prescribed by a qualified medical practitioner.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.
- transportation costs to transfer a patient and one additional person (if necessary) to receive medical services, if conditions for transportation expenses are satisfied and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, if conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- costs of acquisition, care and maintenance (including food and veterinary care) of an animal specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs.
- modifications to the principal home of the person who lacks normal physical development or who has severe and prolonged mobility impairment, to enable the person to gain access to a dwelling or to be functional within it.
- reasonable expenses to locate a bone marrow or organ transplant donor, and reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.

Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Other coverage

If you or your eligible dependents have coverage under another plan, you should submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

When coverage ends

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

Surviving dependent coverage

The remaining credits in the account on the date of the employee's death, can be used to pay for expenses incurred by the dependents during the 12 months following the employee's death. New annual credits will also be allocated to he Health Spending Account after the employee’s death, while the dependents are eligible for benefits.

Personal Spending Account for Contract Number 151039

Administrator

This Personal Spending Account is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has established a Personal Spending Account and has the sole legal and financial liability for this Personal Spending Account under the Personal Spending Account Services Contract entered into with Sun Life. Sun Life only acts as administrator.

Your employer will be responsible for all payroll related deductions and issuing the appropriate tax information slips related to your Personal Spending Account.

Your Personal Spending Account coverage provides reimbursement to you for expenses described in this section under *Eligible expenses*.

An expense is incurred on the date the expense is billed. Eligible expenses incurred by your dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Personal Spending Account and before the date the Personal Spending Account ends.

Your dependent must be your spouse/partner or your children and any other member of your family or your spouse's/partner's family who are dependent on you for financial support, such as parents, grandparents or grandchildren, and a resident of Canada or the United States. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care or Dental Care benefits.

The benefit year is indicated in the Benefit Summary.

How your Personal Spending Account works	Your Personal Spending Account works like an expense account. Your employer will allocate credits to your Personal Spending Account in the manner described under *Credits* in the Benefit Summary. Each time you submit a Personal Spending Account claim, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Personal Spending Account.
Balance carry-forward	This Personal Spending Account is set up with a ***balance carry-forward*** feature. This means that you may be reimbursed for eligible expenses incurred in a benefit year using credits received during that benefit year, as well as any unused credits that have been carried forward from the previous benefit year. In other words, any credits remaining in your Personal Spending Account at the end of one benefit year will be carried forward and may be used to reimburse you for eligible expenses incurred in the following benefit year. Credits that are carried forward from one benefit year to the next will be lost at the end of the second benefit year if you have not used them by then. Carried forward credits are always used before new credits are used. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Eligible expenses

You can use your Personal Spending Account to help you pay for the following eligible expenses:

Fitness-related services

- fitness club memberships.
- registration fees for virtual fitness classes.
- registration fees for fitness-related programs or lessons, such as aerobic classes, yoga, dance lessons, figure skating and martial arts.
- sports team memberships and registration fees.
- annual memberships or daily passes to athletic facilities (such as golf courses, racquet clubs and ski hills).
- annual memberships, such as ski passes and golf.
- court fees, green fees, ski passes, lift tickets and race registrations.
- personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.
- registration fees for fitness-related events (such as walks, runs and races).
- recreational activity fees (such as boating fees, camping fees and trail passes).
- fees for athletic facilities and equipment rental costs.
- fitness-related apps, software and programs.
- hunting and fishing licenses.

Fitness equipment

- durable equipment such as treadmills, exercise bikes and universal gym.
- skates, roller blades, bicycles, tennis racquets, golf clubs, safety helmets and specialized sports equipment.
- fitness tracking tools (including watches) and heart-rate monitors.

Health-related services

- weight management programs (excluding food).
- healthy cooking classes
- smoking cessation programs.
- nutrition programs and counselling.
- maternity services (prenatal classes and mid-wife services).
- services of the following alternative health practitioners: reflexologist, iridologist, herbalist, homeopath, athletic therapist, Chinese medical practitioner, Shiatsu therapist, osteopathic practitioner, acupressurist, exercise physiologist and occupational therapist.
- stress management programs.
- cholesterol and hypertension screening.
- first aid and CPR (cardiopulmonary resuscitation) training.
- health, fitness or lifestyle assessments (such as fees for allergy testing, ergonomic assessments and genetic testing).
- health assessments.
- orthopaedic pillow and mattresses.
- allergy tests.
- vitamins and supplements, including herbal products.
- sleeping aids (such as orthopaedic mattresses and pillows, darkening blinds, white noise machines and ear plugs).
- life coach services or fees for spiritual or wellness retreats (excludes the cost of travel and accommodations).
- other alternative wellness services: Reiki, Ayurvedic medicine, touch therapy, Rolfing and light therapy.

Indigenous Health

- traditional Indigenous Healers and Elders.
- traditional medicines (such as sweetgrass, sage, cedar, tobacco plant).

	• fees and supplies for Indigenous ceremonies (such as sweat lodges, healing circles, smudge kits). **Insurance premiums** • insurance premiums paid for Life and Long Term Disability. • pet insurance premiums. **Educational and personal development** • tuition fees for university, college or continuing education (including books and supplies). • language training. • tutoring. • professional membership fees or dues. • fees associated with maintaining a professional designation. • hobby and general interest classes. • personal computer and accessories. • smartphones and tablets. **Professional services** • services of professionals for estate planning, financial counselling, tax return preparation and will preparation.

When coverage ends

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

Wellness Personal Spending Account for Contract Number 152260

Administrator

This Personal Spending Account is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has established a Wellness Personal Spending Account and has the sole legal and financial liability for this Wellness Personal Spending Account under the Personal Spending Account Services Contract entered into with Sun Life. Sun Life only acts as administrator.

Your employer will be responsible for all payroll related deductions and issuing the appropriate tax information slips related to your Wellness Personal Spending Account.

Your Wellness Personal Spending Account coverage provides reimbursement to you for expenses described in this section under *Eligible expenses*.

An expense is incurred on the date the expense is billed. Eligible expenses incurred by your dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Wellness Personal Spending Account and before the date the Wellness Personal Spending Account ends.

Your dependent must be your spouse/partner or your children and any other member of your family or your spouse's/partner's family who are dependent on you for financial support, such as parents, grandparents or grandchildren, and a resident of Canada or the United States. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care or Dental Care benefits.

The benefit year is indicated in the Benefit Summary.

How your Wellness Personal Spending Account works	Your Wellness Personal Spending Account works like an expense account. Your employer will allocate credits to your Wellness Personal Spending Account in the manner described under *Credits* in the Benefit Summary. Each time you submit a Wellness Personal Spending Account claim, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Wellness Personal Spending Account.
Wellness Personal Spending Account with no carry-forward feature	Any credits remaining in your Wellness Personal Spending Account at the end of a benefit year will be lost. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Eligible expenses	You can use your Wellness Personal Spending Account to help you pay for the following eligible expenses: **Fitness services** • fitness club or gym memberships. • registration fees for virtual fitness classes. • registration fees for fitness-related programs, lessons or courses (such as aerobics, yoga, dance and martial arts). • sports team memberships and registration fees. • annual memberships or daily passes to athletic facilities (such golf courses, racquet clubs and ski hills). • personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.

- registration fees for fitness-related events (such as walks, runs and races).
- recreational activity fees (such as boating fees, camping fees and trail passes).
- fees for athletic facilities and equipment rental costs.
- fitness-related apps, software and programs.
- hunting and fishing licenses.

Fitness equipment

- purchase or rental of exercise equipment (such as treadmills, exercise bikes, universal gyms and weights).
- specialized sports equipment (such as skates, bikes, non-motorized boats, rackets and clubs).
- fitness tracking tools (including watches) and heart-rate monitors.
- fitness consoles and accessories, DVDs and downloadable work-out videos.

Health products and services

- weight management programs (excluding food).
- nutrition programs and counselling.
- cholesterol and hypertension screening.
- smoking cessation programs and products.
- services provided by iridologists, herbalists, Chinese medical practitioners and acupressurists.
- other alternative wellness services (such as Reiki, Rolfing and light therapy).
- stress management programs.
- health, fitness or lifestyle assessments (such as fees for allergy testing, ergonomic assessments and genetic testing).
- vitamins, supplements, herbal products, blenders and juicers.
- life coach services or fees for spiritual or wellness retreats (excludes the cost of travel and accommodations).
- health-related apps, software and programs.

Indigenous Health

- traditional Indigenous Healers and Elders.
- traditional medicines (such as sweetgrass, sage, cedar, tobacco plant).
- fees and supplies for Indigenous ceremonies (such as sweat lodges, healing circles, smudge kits).

When coverage ends

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

Surviving dependent coverage

The Wellness Personal Spending Account is set up under the employee's name, and there is no continuation of coverage for dependents after the employee's death. Only eligible expenses incurred before the employee's death can be reimbursed under the employee's Wellness Personal Spending Account.

Long-Term Disability

Insurer

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

General description of the coverage

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

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

For the purposes of your Long-Term Disability coverage:

- during the elimination period and the following 24 months (this period is known as the own occupation period), we consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own occupation, in any workplace, including in a different department or location with your employer or with another employer, and
- afterwards, we will consider you to be totally disabled while you are continuously unable due to an illness to perform any occupation, for any employer, for which you are or may become reasonably qualified by education, training or experience.

The availability of work with any employer does not affect the determination of total disability.

We pay these benefits at the end of each month. We base them on your coverage on the date you became totally disabled.

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

When disability payments begin	Your Long-Term Disability payments begin **on the later of** the following dates: • after you have been totally disabled for the uninterrupted period indicated in the Benefit Summary. • after the last day benefits are payable under any short-term disability, loss of income replacement (excluding income received from the employer as a direct result of an approved W.C.B. related disability claim) or other salary continuation plan, whichever is later. This period, which must be completed before disability benefits become payable is called the **elimination period.**
What we will pay	Here is how we calculate your Long-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions. **Step 1: We take the maximum amount indicated in the Benefit Summary.** **Step 2: We subtract any benefits or payments provided under:** • any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan*, excluding any benefits or payments on behalf of a dependent, in connection with the same or a subsequent disability. • any Workers' Compensation Act or similar law for the same or a subsequent disability. • a motor vehicle insurance plan. • as part of an income replacement received from the employer as a direct result of an approved Workers' Compensation Board related disability claim. • a group plan, including any coverage you have because you are a member of an

association but excluding any benefits or payments provided under a Critical Illness plan.
- a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- the Québec Parental Insurance Plan.

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

Take the result you got in Step 2, add the above sources of benefits and payments plus the other sources of benefits and payments listed below and check the total you get. If it's more than 85% of your eligible compensation when your disability began, we will reduce your Long-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Other sources of benefits and payments:

- any Workers' Compensation Act or similar law for another disability.
- any Criminal Injuries Compensation Act or similar law.

Important to remember:

- *If you first become entitled to Québec Pension Plan (QPP) disability benefits:
  - before age 60, we will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.
  - on or after age 60, we will deduct the amount provided in your NOE and an additional amount. The additional amount represents a portion of the retirement amount, payable or available following an approved QPP disability application, and is comparable to the variable portion of QPP disability benefits for persons under age 60. These deducted amounts will not change for the duration of your disability claim.
- There are times when we will estimate the amount of the benefits or payments you are entitled to and deduct the estimated amount from your monthly disability benefit. Refer to your group contract for more information.
- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Long-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability reoccurs due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 12 months of the end of your previous disability.

We will base these benefits on your coverage as it existed on the original date you become totally disabled.

Rehabilitation / Partial disability program

Sun Life may require you to participate in a partial disability or rehabilitation program that we have approved in writing.

This may include one or more of the following:

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

During your rehabilitation program, you may receive Long-Term Disability payments plus income, benefits and payments from other sources.

However, if during any month the total of any income, benefits and payments provided is more than 100% of your eligible compensation when your disability began, indexed for inflation, your Long-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

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

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

If you recover damages from another person

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

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

For disability benefits paid or payable prior to the date of judgment or settlement, if you recover money, you must pay us 75% of your net recovery or the total disability benefits paid or payable to you under this plan, whichever is less. For disability benefits payable after a judgment or settlement, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits. Refer to your group contract for more information.

What you are responsible to do

During your total disability, you must make reasonable efforts to do all of the following. If you do not, Sun Life may reduce, hold back or discontinue benefits.

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

When payments end

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

- the date you are no longer totally disabled.
- the end of the maximum benefit period indicated in the Benefit Summary.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

Survivor benefit

If you die while you are receiving Long-Term Disability payments, we will pay 3 times your last monthly payment to your spouse/partner, dependent children or your estate.

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off.
- you are absent from Canada longer than 4 months due to any reason.

- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if you become totally disabled within 12 months after your coverage begins and your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if you have been covered for Long-Term Disability with your employer for at least 13 weeks during which:

- you have been actively working continuously (up to 3 days of absence does not count), and
- you have not been treated for the condition by a doctor or any medical personnel under the direction of a doctor.

If your coverage ends but you are covered again under this plan, we will use the latest date your coverage began when applying the above limitation.

We will not pay benefits for total disability resulting from:

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

Waiver of premium

Long-Term Disability premiums will be waived while you are receiving Long-Term Disability benefits.

Life Coverage

Insurer

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

General description of the coverage

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

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

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

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

Converting Life coverage

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

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

The request must be made within 31 days that the Life coverage reduces or ends.

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

Basic A.D.&D. Insurance

Insurer

This benefit is insured by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

Coverage
Any Accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

Eligibility
You are eligible as an Insured Person if you are an active employee under age 70.

Amount of Insurance
Your amount of insurance (Principal Sum) is equal to two times your annual earnings rounded up to the next higher $1,000.00 if not already an even multiple of $1,000.00 to a maximum of $1,000,000.00. Your Principal Sum reduces by 50% upon attainment of age 65.

Benefits

Accidental Death, Dismemberment and Specific Loss Indemnity

If, within 12 months of the date of the Accident, Injury results in any of the following losses, the insurer will pay for:

Loss of:

Life	The Principal Sum
Brain Death	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and the Entire Sight of One Eye	The Principal Sum
One Foot and the Entire Sight of One Eye	The Principal Sum
Speech and Hearing in Both Ears	The Principal Sum
One Arm	Three-Quarters of the Principal Sum
One Leg	Three-Quarters of the Principal Sum
One Hand	Two-Thirds of the Principal Sum
One Foot	Two-Thirds of the Principal Sum
Entire Sight of One Eye	Two-Thirds of the Principal Sum
Speech	Two-Thirds of the Principal Sum
Hearing in Both Ears	Two-Thirds of the Principal Sum
Thumb and Index Finger of Same Hand	One-Third of the Principal Sum
Four Fingers of Same Hand	One-Third of the Principal Sum
Hearing in One Ear	One-Third of the Principal Sum
All Toes of Same Foot	One-Quarter of the Principal Sum

Loss of Use of:

Both Arms	Two Times the Principal Sum
Both Hands	Two Times the Principal Sum
Both Legs	Two Times the Principal Sum
Both Feet	Two Times the Principal Sum
One Arm	Three-Quarters of the Principal Sum
One Leg	Three-Quarters of the Principal Sum
One Hand	Two-Thirds of the Principal Sum

PARALYSIS BENEFITS

Quadriplegia (complete paralysis of both upper and lower limbs) ..... Two Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs) ..... Two Times the Principal Sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of body) ..... Two Times the Principal Sum

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one Accident will not exceed the following:

(a) With the exception of Loss of Use of Both Arms, Both Hands, Both Legs, Both Feet, as well as Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;
(b) With respect to Loss of Use of Both Arms, Both Hands, Both Legs, Both Feet, as well as Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the Accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same Accident.

The maximum amount payable for Quadriplegia, Paraplegia or Hemiplegia will not exceed $1,500,000.00 in combination with the maximum stated for Quadriplegia, Paraplegia or Hemiplegia in all other policies issued to the Policyholder by the insurer.

“Accident” or “Accidental” whenever used in the policy means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while the policy is in force and be the basis of claim.

“Injury” whenever used in the policy means bodily injury caused by an Accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

“Loss” whenever used in the policy with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

“Loss of Use” whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the Accident.

Bereavement Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred by your spouse/partner and dependent children for up to six sessions of grief counseling, by a professional counselor, subject to a maximum of $1,000.00.

Continuation of Coverage
Your coverage under the policy may be continued during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave, provided payment of premium is continued.

Conversion Option
Upon termination of active employment with your employer, you may, within 31 days following the date of such termination, make written application to convert to an individual Accident insurance plan with no evidence of insurability required, at the individual rates in force with the insurer at the time of your termination. You may elect an amount of Principal Sum equal to or lower than the amount of Principal Sum in force under all policies issued to your employer by the insurer to a maximum of $500,000.00. This benefit is restricted to *Canadian* residents only.

Cosmetic Disfigurement Benefit
When, as a result of a non-occupational Injury, you suffer cosmetic disfigurement due to a third-degree burn, the insurer will pay a percentage of your Principal Sum based on the amount of body surface burned as determined by the attending physician and as outlined in the policy.

If you suffer burns to more than one body part as a result of any one Accident, benefits payable for all such burns will not exceed a maximum of $25,000.00.

Day Care Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000.00, for each of your dependent children under 13 years of age who (a) are enrolled in a legally licensed day care centre on the date of your death; or (b) enroll in a legally licensed day care centre within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre, but not to exceed four consecutive annual payments with respect to any one dependent child.

Education Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000.00, for each of your dependent children who (a) are enrolled as full-time students in a school for higher learning above the secondary school level; or (b) were enrolled as full-time students at the secondary school level but enroll as full-time students in a school for higher learning within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning, but not to exceed four consecutive annual payments with respect to any one dependent child. If, at the time of loss, you have no dependent children eligible for the Education Benefit, the insurer shall pay an additional amount of $2,500.00 to your designated beneficiary.

Family Transportation Benefit
If, following an Injury which results in a Loss covered by the policy, you are confined as an in-patient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the insurer will pay the reasonable and necessary expenses actually incurred by any one member of your immediate family for hotel accommodation and transportation by the most direct route to you, subject to a maximum of $15,000.00 for all such expenses.

Home Alteration and Vehicle Modification Benefit
If, following an Injury which results in a Loss covered by the policy, you are required to use a wheelchair to be ambulatory, the insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the Accident causing such Loss for (a) the cost of alterations to your principal residence; and/or (b) the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by the provincial vehicle licensing authorities where required for the purpose of making them wheelchair accessible, subject to 10% of your Principal Sum to a maximum of $50,000.00, or $15,000.00, whichever is greater, as the result of any one Accident.

Identification Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, and provided identification of your body is required by the police or similar law enforcement agency, the insurer will pay the reasonable and necessary expenses actually incurred by a member of your immediate family for lodging and board (not to exceed a maximum duration of three consecutive nights) and transportation by the most direct route to and from the location of your body, subject to a maximum of $15,000.00. The body's location must not be less than 150 kilometers from the family member's normal place of residence.

In-Hospital Indemnity Benefit
If, following an Injury, you are confined in a hospital as a resident in-patient for more than five consecutive days, the insurer will pay (a) a monthly benefit of one percent of your Principal Sum; or (b) for periods of less than one month, one thirtieth of the above monthly benefit per day. This benefit is limited to (a) a monthly amount not to exceed $2,500.00 and (b) a total of 12 months for any covered Accident. Benefits are retroactive to the first day of hospital confinement.

Rehabilitation Benefit
If, following an Injury which results in a Loss covered by the policy, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the insurer will pay the reasonable and necessary expense incurred for such training within two years of the date of the Accident, subject to a maximum of $15,000.00 as the result of any one Accident.

Repatriation Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for preparation and transport of your body to your city of residence, subject to a maximum of $15,000.00.

Seat Belt Benefit
If, due to a vehicular Accident, Injury results in a loss covered by the policy, your Principal Sum will be increased by 10% to a maximum of $25,000.00 if, at the time of the Accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver of the vehicle must hold a current and valid driver's license authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs at the time of the Accident. Due proof of seat belt use must be provided as part of the written proof of loss.

Spousal Retraining Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such Accident by your spouse/partner who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, subject to a maximum of $15,000.00 for all such expenses.

Surgical Reattachment Benefit
If Injury results in the complete severance of your limb or appendage or part of either your limb or appendage, and if such severed limb, appendage or part is surgically reattached, the insurer will pay the Surgical Reattachment Benefit in accordance with the applicable benefit under "Accidental Death, Dismemberment and Specific Loss Indemnity". The maximum amount payable for this benefit and "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy is the Principal Sum for all losses sustained by you as the result of any one Accident.

Waiver of Premium
In the event you become totally disabled while under age 65 and your waiver of premium claim is accepted and approved under your employer's current Group Life policy, premiums payable under the Basic A.D.&D. policy will be waived as of the same date the claim is accepted and approved by the Group Life policy Underwriter.

Aggregate Limit of Indemnity
The policy is subject to the following Aggregate Limits of Indemnity:

(a) $2,900,000.00 for all losses resulting from any one *aircraft* Accident under Basic A.D.&D. Policy No. 100011489; or
(b) $15,000,000.00 for all losses resulting from any one *offshore oil rig* Accident, combined under Basic A.D.&D. Policy No. 100011489 and Voluntary A.D.&D. Policy No. 100011496; or
(c) $3,000,000.00 for all losses resulting from any one Accident *while travelling to and from an offshore oil rig,* combined under Basic A.D.&D. Policy No. 100011489 and Voluntary A.D.&D. Policy No. 100011496.

This means that in the event of an Accident that results in an accumulation of losses exceeding $2,900,000.00, $15,000,000.00 or $3,000,000.00 (as applicable), the amount payable with respect to each Insured Person will be reduced proportionately.

Exclusions
Cover does not apply to any loss caused or contributed to by:

- declared or undeclared war or any act of war;
- active full-time service in the armed forces of any country;
- suicide or self-destruction, while sane or insane;
- flying as a pilot or crew member in any aircraft;
- flying in owned, operated or leased aircraft of your employer.

Exposure and Disappearance
If due to Accident you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the Accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury.

Where, due to the Accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

Beneficiary
The beneficiary or beneficiaries of an Insured Person shall be that person or those persons designated by the Insured Person and filed with the employer. If no such designation has been filed, the beneficiary in respect of loss of life of an Insured Person shall be the estate of the Insured Person. All other indemnities payable will be payable to the Insured Person, with the exception of indemnities payable under “Bereavement Benefit”, “Day Care Benefit”, “Education Benefit”, “Family Transportation Benefit”, “Identification Benefit” and “Spousal Retraining Benefit”.

Termination of Insurance
Your insurance will immediately terminate on the earliest of the following dates:

(a) the date the policy is terminated;
(b) the premium due date if your employer fails to remit your premium to the insurer, except as the result of an inadvertent error;
(c) the premium due date coinciding with or immediately following the date you retire or reach 70 years of age, whichever is earlier;
(d) the premium due date coinciding with or immediately following the date you cease to be associated with your employer in a capacity making you eligible for insurance, except as provided under the part titled “Continuation of Coverage”.

A.D.&D. Claims Procedures
Written notice of claim is to be given to the insurer within a period of 30 days from the date of the Accident. Claim forms are available from your plan administrator or from the insurer at (800) 266-5667. The insurer reserves the right to request additional information when processing the claim. Completed claim forms must be filed with the insurer within 90 days after the date of the Injury and no later than one year regardless of whether the full extent of loss is known.

In the situation where this policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the Insured Person.

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.

This wording is for illustrative purposes only and carries no contractual or other rights. All rights with respect to the benefits of an Insured Person will be governed by the Group Master Policy, a copy of which is filed with your employer.

Voluntary A.D.&D. Insurance

Insurer

This benefit is insured by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

Coverage

Any Accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

Eligibility

You are eligible to enroll as an Insured Person if you are an active full-time employee under age 70. You may also enroll your spouse/partner and/or unmarried dependent children. Unmarried children are those under age 21 or to age 26 if attending college or other school on a full-time basis and are dependent on your support.

Amount of Insurance

Employee Only Plan

You may select any amount of insurance (Principal Sum) for yourself from a minimum of $25,000.00 to a maximum of $500,000.00 in units of $25,000.00.

Spouse/Partner Only Plan

You may select any amount of insurance (Principal Sum) for your spouse/partner from a minimum of $25,000.00 to a maximum of $500,000.00 in units of $25,000.00.

Dependent Children Only Plan

You may select any amount of insurance (Principal Sum) for your dependent children from a minimum of $5,000.00 to a maximum of $25,000.00 in units of $5,000.00.

In the event your spouse/partner is an eligible employee of your employer, you each may enroll. One would elect the Employee Only Plan; the other may elect the Employee Only Plan and Dependent Children Only Plan. If one spouse/partner does not enroll, the other may also elect the Spouse/Partner Only Plan.

Effective Date

Coverage will begin on the first day of the month following the date your completed enrollment is received by your employer and coincident with payroll deductions.

Benefits

Accidental Death, Dismemberment and Specific Loss Indemnity

The policy provides benefits for Injury which occurs within 12 months after the date of the Accident as follows:

Loss of:

Life	The Principal Sum
Brain Death	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and the Entire Sight of One Eye	The Principal Sum
One Foot and the Entire Sight of One Eye	The Principal Sum

Speech and Hearing in Both Ears	The Principal Sum
One Arm	Three-Quarters of the Principal Sum
One Leg	Three-Quarters of the Principal Sum
One Hand	Two-Thirds of the Principal Sum
One Foot	Two-Thirds of the Principal Sum
Entire Sight of One Eye	Two-Thirds of the Principal Sum
Speech or Hearing in Both Ears	Two-Thirds of the Principal Sum
Thumb and Index Finger of Same Hand	One-Third of the Principal Sum
Four Fingers of Same Hand	One-Third of the Principal Sum
Hearing in One Ear	One-Third of the Principal Sum
All Toes of Same Foot	One-Quarter of the Principal Sum

Loss of Use of:

Both Arms	Two Times the Principal Sum
Both Hands	Two Times the Principal Sum
Both Legs	Two Times the Principal Sum
Both Feet	Two Times the Principal Sum
One Arm	Three-Quarters of the Principal Sum
One Leg	Three-Quarters of the Principal Sum
One Hand	Two-Thirds of the Principal Sum

PARALYSIS BENEFITS

Quadriplegia (complete paralysis of both upper and lower limbs)	Two Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs)	Two Times the Principal Sum
Hemiplegia (complete paralysis of upper and lower limbs of one side of body)	Two Times the Principal Sum

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one Accident will not exceed the following:

(a) With the exception of Loss of Use of Both Arms, Both Hands, Both Legs, Both Feet, as well as Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;
(b) With respect to Loss of Use of Both Arms, Both Hands, Both Legs, Both Feet, as well as Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the Accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same Accident.

The maximum amount payable for Quadriplegia, Paraplegia or Hemiplegia will not exceed $1,500,000.00 in combination with the maximum stated for Quadriplegia, Paraplegia or Hemiplegia in all other policies issued to the Policyholder by the insurer.

“Accident” or “Accidental” whenever used in the policy means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while the policy is in force and be the basis of claim.

“Injury” whenever used in the policy means bodily injury caused by an Accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

“Loss” whenever used in the policy with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

“Loss of Use” whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the Accident.

Bereavement Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred by your spouse/partner and dependent children for up to six sessions of grief counseling, by a professional counselor, subject to a maximum of $1,000.00.

Continuation of Coverage
Your coverage under the policy may be continued during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave, provided payment of premium is continued.

Conversion Option
Upon termination of active employment with your employer, you may, within 31 days following the date of such termination, make written application to convert your insurance only (but not that of your insured spouse/partner and/or insured dependent children) to an individual Accident insurance plan with no evidence of insurability required, at the individual rates in force with the insurer at the time of your termination. You may elect an amount of Principal Sum equal to or lower than the amount of Principal Sum in force under all policies issued to the Policyholder by the insurer to a maximum of $500,000.00. This benefit is restricted to *Canadian* residents only.

Cosmetic Disfigurement Benefit
When, as a result of a non-occupational Injury, you, your insured spouse/partner or insured dependent child suffer cosmetic disfigurement due to a third-degree burn, the insurer will pay a percentage of the applicable Principal Sum based on the amount of body surface burned as determined by the attending physician and as outlined in the policy.

If you, your insured spouse/partner or insured dependent child suffer burns to more than one body part as a result of any one Accident, benefits payable for all such burns will not exceed a maximum of $25,000.00

Day Care Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000.00, for each of your dependent children under 13 years of age who (a) are enrolled in a legally licensed day care centre on the date of your death; or (b) enroll in a legally licensed day care centre within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre, but not to exceed four consecutive annual payments with respect to any one dependent child.

Education Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000.00, for each of your dependent children who (a) are enrolled as full-time students in a school for higher learning above the secondary school level; or (b) were enrolled as full-time students at the secondary school level but enroll as full-time students in a school for higher learning within 12 months after the date of your death.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning, but not to exceed four consecutive annual payments with respect to any one dependent child. If, at the time of loss, none of your dependent children are eligible for the Education Benefit, the insurer shall pay an additional amount of $2,500.00 to your designated beneficiary.

Family Transportation Benefit
If, following an Injury which results in a Loss covered by the policy, you, your insured spouse/partner or insured dependent child are confined as an in-patient in a hospital located from a point of not less than 150 kilometers from the normal place of residence, the insurer will pay the reasonable and necessary expenses actually incurred by any one member of the immediate family for hotel accommodation and transportation by the most direct route to you, your insured spouse/partner or insured dependent child, subject to a maximum of $15,000.00 for all such expenses.

Home Alteration and Vehicle Modification Benefit
If, following an Injury which results in a Loss covered by the policy, you, your insured spouse/partner or insured dependent child are required to use a wheelchair to be ambulatory, the insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the Accident causing such Loss for (a) the cost of alterations to the principal residence; and/or (b) the cost of modifications to one motor vehicle utilized by you, your insured spouse/partner or insured dependent child, when such modifications are approved by the provincial vehicle licensing authorities where required for the purpose of making them wheelchair accessible, subject to 10% of the applicable Principal Sum to a maximum of $50,000.00, or $15,000.00, whichever is greater, as the result of any one Accident.

Identification Benefit
If Injury results in loss of life for you, your insured spouse/partner or insured dependent child and indemnity becomes payable under the policy, and provided identification of the body is required by the police or similar law enforcement agency, the insurer will pay the reasonable and necessary expenses actually incurred by a member of the immediate family for lodging and board (not to exceed a maximum duration of three consecutive nights) and transportation by the most direct route to and from the location of the body, subject to a maximum of $15,000.00. The body's location must not be less than 150 kilometers from the family member's normal place of residence.

In-Hospital Indemnity Benefit
If, following an Injury, you are confined in a hospital as a resident in-patient for more than five consecutive days, the insurer will pay (a) a monthly benefit of one percent of your Principal Sum; or (b) for periods of less than one month, one thirtieth of the above monthly benefit per day. This benefit is limited to (a) a monthly amount not to exceed $2,500.00 and (b) a total of 12 months for any covered Accident. Benefits are retroactive to the first day of hospital confinement.

Rehabilitation Benefit
If, following an Injury which results in a Loss covered by the policy, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the insurer will pay the reasonable and necessary expense incurred for such training within two years of the date of the Accident, subject to a maximum of $15,000.00 as the result of any one Accident.

Repatriation Benefit
If Injury results in loss of life for you, your insured spouse/partner or insured dependent child and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for preparation and transport of the body to the city of residence, subject to a maximum of $15,000.00.

Seat Belt Benefit
If, due to a vehicular Accident, Injury results in a loss covered by the policy, the Principal Sum applicable to you, your insured spouse/partner or insured dependent child will be increased by 10% to a maximum of $25,000.00 if, at the time of the Accident, you, your insured spouse/partner or insured dependent child were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver of the vehicle must hold a current and valid driver's license authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs at the time of the Accident. Due proof of seat belt use must be provided as part of the written proof of loss.

Spousal Retraining Benefit
If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such Accident by your spouse/partner who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, subject to a maximum of $15,000.00 for all such expenses.

Surgical Reattachment Benefit
If Injury results in the complete severance of your, your insured spouse's/partner's or insured dependent child's limb or appendage or part of either a limb or appendage, and if such severed limb, appendage or part is surgically reattached, the insurer will pay the Surgical Reattachment Benefit in accordance with the limitations outlined in the policy. The maximum amount payable for this benefit and "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy is the Principal Sum for all losses sustained by you, your insured spouse/partner or insured dependent child as the result of any one Accident.

Waiver of Premium
In the event you become totally disabled while under age 65 and your waiver of premium claim is accepted and approved under your employer's current Group Life policy, premiums payable under the Voluntary A.D.&D. policy will be waived as of the same date the claim is accepted and approved by the Group Life policy Underwriter.

Aggregate Limit of Indemnity

The policy is subject to the following Aggregate Limits of Indemnity:

(a) $15,000,000.00 for all losses resulting from any one *offshore oil rig* Accident, combined under Basic A.D.&D. Policy No. 100011489 and Voluntary A.D.&D. Policy No. 100011496; or
(b) $3,000,000.00 for all losses resulting from any one Accident *while travelling to and from an offshore oil rig,* combined under Basic A.D.&D. Policy No. 100011489 and Voluntary A.D.&D. Policy No. 100011496.

This means that in the event of an Accident that results in an accumulation of losses exceeding 15,000,000.00 or $3,000,000.00 (as applicable), the amount payable with respect to each Insured Person will be reduced proportionately.

Exclusions
Cover does not apply to any loss caused or contributed to by:

- declared or undeclared war or any act of war;
- active full-time service in the armed forces of any country;
- suicide or self-destruction, while sane or insane;
- flying as a pilot or crew member in any aircraft;
- flying in owned, operated or leased aircraft of your employer.

Exposure and Disappearance
If due to Accident you, your insured spouse/partner or insured dependent child are unavoidably exposed to the elements and such exposure, within 12 months of the date of the Accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury.

Where, due to the Accidental wrecking, sinking or disappearance of a conveyance in which you, your insured spouse/partner or insured dependent child were riding, you, your insured spouse/partner or insured dependent child disappear, and if the body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you, your insured spouse/partner or insured dependent child suffered loss of life as a result of Injury.

Cost of Insurance
The premium for the coverage you select will be obtained by payroll deduction. The premium rate for the Employee Only Plan is $.0285 per month for each $1,000.00 of insurance. The Spouse/Partner Only Plan is $.025 per month for each $1,000.00 of insurance. The Dependent Child Only Plan is $.20 per month for each $1,000.00 of insurance for all dependent children.

Beneficiary
The beneficiary or beneficiaries of an employee shall be that person or persons designated in writing by the employee on his enrollment form on file with the employer. If no such beneficiary designation has been filed, the beneficiary in respect of loss of life of an employee shall be the estate of the employee. All other indemnities payable, including those payable for the insured spouse/partner and/or insured dependent children, are payable to the employee, with the exception of indemnities payable under "Bereavement Benefit", "Day Care Benefit", "Education Benefit", "Family Transportation Benefit", "Identification Benefit", and "Spousal Retraining Benefit".

Termination of Insurance
Your insurance will immediately terminate on the earliest of the following dates:

(a) the date the policy is terminated;
(b) the premium due date if your employer fails to remit your premium to the insurer, except as the result of an inadvertent error;
(c) the premium due date coinciding with or immediately following the date you reach 70 years of age or retirement, whichever is earlier;

(d) the premium due date coinciding with or immediately following the date you cease to be associated with your employer in a capacity making you eligible for insurance, except as provided under the part titled “Continuation of Coverage”.

Your insured spouse’s/partner’s and/or insured dependent children’s insurance will terminate on the earliest of the following dates:

(a) the date such person ceases to be an eligible person;
(b) the date your insurance is terminated.

A.D.&D. Claims Procedures

Written notice of claim is to be given to the insurer within a period of 30 days from the date of the Accident. Claim forms are available from your plan administrator or from the insurer at (800) 266-5667. The insurer reserves the right to request additional information when processing the claim. Completed claim forms must be filed with the insurer within 90 days after the date of the Injury and no later than one year regardless of whether the full extent of loss is known.

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.

This wording is for illustrative purposes only and carries no contractual or other rights. All rights with respect to the benefits of an Insured Person will be governed by the Group Master Policy, a copy of which is filed with your employer.

Canada Short Term Disability Benefit

Insurer

This benefit is insured by Schlumberger Canada Limited

Your Short-Term Disability Plan

Short-term disability (STD) coverage provides you with income protection in the event of a non work-related illness or injury; however, there are some differences in coverage, as noted in the table below. Your STD coverage is automatic and fully paid for under SLB Flex.

Employee Status	**Onset of STD to 26 weeks (maximum 6 months)**	**27 weeks to 52 weeks (maximum 12 months)**
All Employees	100% of Base Salary	80% of Base Salary
Legacy SLB Field Direct Employees	130% of Base Salary	110% of Base Salary

For more information, please review the Canada Short Term Disability Benefit Policy on the Benefits Central website: **https://slb-benefits.ca**.

Voluntary Group Critical Illness Insurance

Insurer

This benefit is insured by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

*This Insurance Benefits Summary is designed to outline the Voluntary Group Critical Illness Insurance benefits which are available to you (and your dependents, when insured) under Group Policy 100013286 issued to Schlumberger Canada Limited by Industrial Alliance Insurance and Financial Services Inc. (the **Company**) which is available to you upon request. This Group Policy contains a provision removing or restricting the right of the Insured Person to designate persons to whom or for whose benefit insurance money is payable. In the event of any variation between the Group Insurance Certificate, this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Policy which may be amended from time to time.*

BENEFIT SCHEDULE

You, your Spouse and Dependent Children are insured for benefits indicated on your Group Insurance Certificate.

PLAN DESCRIPTION EMPLOYEE OR SPOUSE COVERAGE

Covered Condition Benefit

If an Insured Employee or Insured Spouse is diagnosed by a Specialist with a Covered Condition while Voluntary Group Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay such Insured Person the Voluntary Group Critical Illness Insurance Benefit Amount in force (the **Covered Condition Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies before the approved Covered Condition Benefit is paid, the Covered Condition Benefit will be paid to the Insured Person's estate. In the event an Insured Person receives a simultaneous Diagnosis of multiple Covered Conditions, the Company will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (MEC Grouping) shown in the **Multiple Event Coverage Benefit** section, starting with MEC Grouping Group 1.

Cancer Recurrence Benefit

If an Insured Employee or Insured Spouse receives a Diagnosis of Cancer under the Group Policy, and thereafter the Insured Person is diagnosed with Cancer again only as described below, the Company will pay the Insured Person the Benefit Amount in force (the **Cancer Recurrence Benefit**) subject to the terms and conditions of the Group Policy. **Cancer Recurrence** means an Insured Person receives a subsequent Diagnosis of Cancer, provided that:

a) more than 60 months have passed between the previous Cancer Date of Diagnosis and the date of the subsequent Diagnosis;

b) the Insured Person has not received any treatment relating directly or indirectly to the previous cancer within a continuous 60-month period prior to the subsequent Diagnosis;

c) the Insured Person does not have any new signs, symptoms or deliberate or incidental findings, during a continuous 60-month period prior to the subsequent Diagnosis, for which they sought medical investigation, consultation to investigate and/or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused an individual to seek the same relating to a Diagnosis of any cancer covered or excluded under the Group Policy; and

d) both the first and subsequent diagnoses are made subsequent to the effective date of coverage under the Group Policy and prior to the termination date of coverage under the Group Policy.

Multiple Event Coverage Benefit

If an Insured Employee or Insured Spouse receives a Covered Condition Benefit under the Group Policy, and thereafter the Insured Person is diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**MEC Grouping**), the Company will pay such Insured Person the Voluntary Group Critical Illness Insurance Benefit Amount in force (the **Multiple Event Coverage Benefit**), subject to the terms and conditions of the Group Policy. The Insured Person must survive for 30 days following the Date of Diagnosis or such longer survival period as described in certain Covered Conditions to qualify for this benefit. If an Insured Person dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to such Insured Person's estate.

MEC Grouping	Covered Condition
Group 1	Cancer
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

AdvanceCare Benefit

If an Insured Employee or Insured Spouse is diagnosed by a Specialist with an AdvanceCare Benefit Condition while Voluntary Group Critical Illness Insurance is in force, the Company will pay such Insured Person a benefit equivalent to 10% of the Benefit Amount in force (the **AdvanceCare Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to such Insured Person's estate. The AdvanceCare Benefit is a one-time benefit for which the Company will pay for one AdvanceCare Benefit Condition only. Payment of the AdvanceCare Benefit will not affect the amount of benefit payment under a Covered Condition Benefit or a Multiple Event Coverage Benefit. Voluntary Group Critical Illness Insurance will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit, providing premiums continue to be paid as required.

Limitations

a) Cancer

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions

for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Cancer (MEC Grouping 1) will no longer be considered a Covered Condition for such Insured Person.

b) Benign Brain Tumour

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Benign Brain Tumour, or has any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

c) Multiple Sclerosis

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Multiple Sclerosis, or has any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

d) Parkinson's Disease and Specified Atypical Parkinsonian Disorders

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, or has any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Policy, Voluntary Group Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

e) AdvanceCare Benefit

An Insured Employee or Insured Spouse will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Voluntary Group Critical Illness Insurance will remain in force, but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Insured Person.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply:

a) No benefit will be paid if a Covered Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;

b) No benefit will be paid if an AdvanceCare Benefit Condition results from any AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;

c) No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

   i) attempted suicide;

ii) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the Insured Person's employment;

iii) taking any drug other than as prescribed by a licensed physician;

iv) war or full-time active service in the armed forces of any country;

v) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;

vi) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Person's blood exceeds 80 milligrams;

vii) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

d) with respect to Voluntary Group Critical Illness Insurance issued as a result of a Special Offer, New Employee Offer or Qualifying Life Event Offer, in addition to the exclusions described above, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, Diagnosis or consultation, including consultation to investigate and/or diagnose (where Diagnosis has not yet been made) was received by the Insured Person or would have been received by a prudent individual within the 24 months immediately preceding the effective date of such Insured Person's coverage. This exclusion applies for the 24 months following the effective date of the Insured Person's Voluntary Group Critical Illness Insurance coverage under the Special Offer, New Employee Offer or Qualifying Life Event Offer.

   NOTE 1: Exclusion d) applicable to the Special Offer, New Employee Offer or Qualifying Life Event Offer coverages, will be removed with respect to an Insured Employee or Insured Spouse in the event that such Insured Person applies for additional Voluntary Group Critical Illness Insurance coverage which is subject to evidence of insurability and such coverage is approved by the Company.

   NOTE 2: If an Insured Employee and/or Insured Spouse was insured on a guaranteed-acceptance basis under the Previous Carrier's Plan, the Pre-existing Condition exclusion described above will be limited to the twelve months immediately preceding the original issue date of such guaranteed-acceptance coverage under the Previous Carrier's Plan and will apply only for the twelve months immediately following the original issue date of such coverage under the Previous Carrier's Plan.

In addition, no benefit will be paid if the Insured Person suffers Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Conversion Privilege

If the Voluntary Group Critical Illness Insurance of an Insured Employee or Insured Spouse terminates as a result of such Insured Person ceasing to be eligible for insurance under the Group Policy and the Insured has not received a Covered Condition Benefit nor an AdvanceCare Benefit from the Company, the Insured Person may, on or before their 65th birthday and without evidence of insurability, convert their terminated Voluntary Group Critical Illness Insurance to a separate critical illness policy (the **Converted Coverage**), issued by the Company subject to the following conditions:

a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be $5,000;

b) the maximum amount of insurance under the Converted Coverage will be limited to the lesser amount of $100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;

c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;

d) the Converted Coverage will be of a type then issued by the Company providing term insurance to age 75;

e) the Converted Coverage will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;

f) the premium rates for the Converted Coverage will be those then in effect for such policy;

g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion; and

h) if a special provision, exclusion and/or limitation had been imposed on the Voluntary Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Coverage.

PLAN DESCRIPTION – DEPENDENT CHILD COVERAGE

Dependent Child Covered Condition Benefit

If an Insured Dependent Child is diagnosed by a Specialist with a Covered Condition while their Dependent Child Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay to the Insured Employee the Benefit Amount in force with respect to such Insured Dependent Child (the **Dependent Child Covered Condition Benefit**), subject to the terms and conditions of the Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Dependent Child dies before the approved Dependent Child Covered Condition Benefit is paid, the Company will pay the Dependent Child Covered Condition Benefit to the Insured Employee.

The Company will pay the Dependent Child Covered Condition Benefit in respect of any Insured Dependent Child for one Covered Condition only.

Notwithstanding the foregoing, with respect to an Insured Dependent Child who is a natural child of the Insured Employee born on or after the effective date of Dependent Child Critical Illness Insurance coverage under the Group Policy:

a) if such Insured Dependent Child, while in the womb, is diagnosed by a Specialist with a Covered Condition, excluding Cancer, Benign Brain Tumour and Multiple Sclerosis, and such Insured Dependent Child survives for 30 days following the effective date of Dependent Child Critical Illness Insurance in respect of such Dependent Child, the Company will pay the Dependent Child Covered Condition Benefit in force to the Insured Employee;

b) if such Insured Dependent Child, while in the womb, is diagnosed by a Specialist with Cancer, Benign Brain Tumour or Multiple Sclerosis, the terms described in Limitations section a) below will apply.

In addition, with respect to an Insured Dependent Child who is a natural child of the Insured Employee born in the first 10 months following the effective date of coverage under the Group Policy, the terms described in Limitations section b) below will apply.

Limitations

a) <u>Cancer, Benign Brain Tumour and Multiple Sclerosis</u>

An Insured Dependent Child will not be entitled to a Dependent Child Covered Condition Benefit for Cancer, Benign Brain Tumour or Multiple Sclerosis and coverage will be void if such Dependent Child has a Diagnosis of Cancer, Benign Brain Tumour or Multiple Sclerosis, or has any signs, symptoms or investigations leading to such Diagnosis, regardless of when the Diagnosis is made, which are initiated within the first 90 days (with respect to Cancer or Benign Brain Tumour) or within the first year (with respect to Multiple Sclerosis) following the effective date of an Insured Dependent Child's coverage.

In addition, an Insured Dependent Child who is a natural child of an Insured Employee born in the first 10 months following the effective date of such Employee's Dependent Child Critical Illness Insurance coverage is not entitled to a Dependent Child Covered Condition Benefit for Cancer, Benign Brain Tumour or Multiple Sclerosis, and coverage will be void if Cancer, Benign Brain Tumour or Multiple Sclerosis was diagnosed while such Dependent Child was in the womb.

In the event that such Insured Dependent Child is the only Insured Dependent Child of the Employee, then applicable premiums paid for Dependent Child Critical Illness Insurance will be refunded.

b) <u>All Covered Conditions excluding Cancer, Benign Brain Tumour and Multiple Sclerosis</u>

An Insured Dependent Child who is a natural child of an Insured Employee born in the 10 month period immediately following the effective date of such Employee's Dependent Child Critical Illness Insurance

coverage, will not be entitled to a Dependent Child Covered Condition Benefit if, within 30 days of birth such Insured Dependent Child has any of the following:

1. a Diagnosis of a Covered Condition or
2. the child's parent or physician notices or becomes aware of any sign, symptom, condition or medical problem that leads to a Diagnosis of a Covered Condition at any time in the future.

In the event of any such Diagnosis with respect to the Insured Dependent Child, of a Covered Condition other than Cancer, Benign Brain Tumour or Multiple Sclerosis, the Dependent Child Critical Illness Insurance will remain in force but the applicable diagnosed Covered Condition will no longer be considered a Covered Condition for such Dependent Child.

Exclusions

In addition to the exclusions included within the definitions of certain Covered Conditions, the following exclusions will also apply.

No benefit will be paid if a Dependent Child's Covered Condition results directly or indirectly from any one or more of the following:

a) any Covered Condition diagnosed prior to the effective date of such child's Dependent Child Critical Illness Insurance coverage.

b) attempted suicide;

c) taking any drug other than as prescribed by a licensed physician;

d) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Dependent Child;

e) war or full-time active service in the armed forces of any country;

f) participation in a criminal act or any attempt to commit a criminal offense, including, but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Dependent Child's blood exceeds 80 milligrams;

g) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;

h) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

In addition, no benefit will be paid if the Insured Dependent Child suffers Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke, as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

With the exception of Dependent Child Critical Illness Insurance approved with medical evidence of insurability, no benefit will be paid if a Covered Condition results directly or indirectly from a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, Diagnosis or consultation, including consultation to investigate and/or diagnose (where Diagnosis has not yet been made) was received by the Insured Dependent Child or would have been received by a prudent individual within the 24 months immediately preceding the effective date of an Insured Dependent Child's coverage. This exclusion applies for the 24 months following the effective date of such Insured Dependent Child's coverage. This exclusion does not apply to a Dependent Child who is a natural child of an Insured Employee born on or after the effective date of such Employee's Dependent Child Critical Illness Insurance coverage.

Notwithstanding the foregoing paragraph, if the Insured Dependent Child was insured under an initial guaranteed-acceptance application under the Previous Carrier's Plan, the pre-existing condition exclusion described above will be limited to the twelve months immediately preceding the original issue date of such guaranteed-acceptance coverage under the Previous carriers plan and will apply only for the twelve months immediately following the original issue date of such coverage under the Previous Carrier's plan. This exclusion does not apply to a Dependent Child who is a natural child of an Insured Employee born on or after the original issue date of guaranteed-acceptance coverage under the Previous Carrier's Plan.

DEFINITIONS

POLICY DEFINITIONS

Administrator means SEB Administrative Services Inc..

AdvanceCare Benefit Conditions are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Employee or Insured Spouse. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

Benefit Amount means the amount of Voluntary Group Critical Illness Insurance or Dependent Child Critical Illness Insurance for which an Insured Person has been approved by the Company, as indicated in the Group Insurance Certificate issued to you.

Covered Conditions with respect to an Insured Employee, Insured Spouse or Insured Dependent Child are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Severe Burns and Stroke, as defined in the section titled Definitions of Covered Conditions – All Insured Persons.

Covered Conditions with respect to an Insured Employee and Insured Spouse only are Dementia including Alzheimer's Disease, Loss of Independent Existence, and Parkinson's Disease and Specified Atypical Parkinsonian Disorders, as defined in the section titled Definitions of Covered Conditions – Employees and Spouses Only.

Covered Conditions with respect to an Insured Dependent Child only are Cerebral Palsy, Congenital Heart Disease, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy and Type 1 Diabetes, as defined in the section titled Definitions of Covered Conditions – Dependent Children Only.

Date of Diagnosis means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions, with Cancer Recurrence, or with one of the AdvanceCare Benefit Conditions.

Dependent Child means your natural child, step-child or legally adopted child who is under 21 years of age, unmarried and receives full parental support and maintenance; or 21 years of age or over but under 25 years of age, unmarried and receives full parental support and maintenance for reason of full-time attendance at a recognized school, college or university.

Diagnosis means the certified diagnosis of the Insured Person with a Covered Condition, with Cancer Recurrence or with one of the AdvanceCare Benefit Conditions by a Specialist.

Employee means an employee (you) as defined in the Group Policy.

Insured Dependent means an Insured Person who is your Spouse or Dependent Child.

Insured Dependent Child means an Insured Person who is your Dependent Child.

Insured Employee means an Insured Person who is an eligible Employee.

Insured Person means a person who is eligible and insured under the Group Policy.

Insured Spouse means an Insured Person who is a Spouse.

Life Event means one of the following events in the life of an Employee:

- Spouse's change of eligibility under their employer's group policy;
- legal marriage or any other formal union recognized by law to a Spouse who is a legal spouse;
- fulfillment of 12 consecutive months of cohabitation in a marriage-like relationship with a Spouse who is a common-law spouse;
- loss of a Spouse through divorce, or formal or informal agreement of separation, whether or not such Spouse was insured under this Policy;
- addition of a Dependent Child through birth or adoption;
- loss of a dependent through death.

Life Event Offer (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to an Employee during a specified enrollment period immediately following a Life Event.

New Employee Offer (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to a new Employee, their Spouse and/or Dependent Children on a guaranteed issue basis during a specified enrolment period following completion of any required eligibility waiting period.

Previous Carrier's Plan means the voluntary group critical illness insurance available to eligible Employees, Spouses and Dependent Children provided to the Policyholder by a previous carrier, existing until midnight of the day preceding the effective date of Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance under the Company Policy.

Special Offer (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to eligible Employees, their Spouses and/or Dependent Children on a guaranteed issue basis during a specified open enrolment period.

Specialist means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

Spouse means your legal or common-law spouse. Legal spouse is a person who is legally married and cohabiting with you and with whom there is no formal or informal agreement of separation. Common-law spouse is a person who has been cohabiting in a marriage-like relationship with you for a period of not less than twelve consecutive months.

DEFINITIONS OF COVERED CONDITIONS – ALL INSURED PERSONS

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

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

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the Date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

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

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- *Pituitary adenomas less than 10 mm;*
- *Vascular malformations;*
- *Cholesteatomas; or*
- *Infectious or inflammatory tumours.*

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms, or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or*
- *A Diagnosis of Benign Brain Tumour (covered or not covered under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or any critical illness caused by any Benign Brain Tumour or its treatment.

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

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

The Diagnosis of Blindness must be made by a Specialist.

Cancer means the definite Diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The Diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:

    - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
    - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- *Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;*
- *Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;*
- *Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;*
- *Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;*
- *Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;*
- *Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;*
- *Gastro-intestinal stromal tumours classified as AJCC Stage 1;*
- *Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or*
- *Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.*

90-Day Exclusion : No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of any cancer (covered or not covered under the Policy), regardless of when the Diagnosis is made; or*
- *A Diagnosis of any cancer (covered or not covered under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or any critical illness caused by any cancer or its treatment.

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

Exclusion: No benefit will be payable under this condition for:

- *A medically induced coma; or,*
- *A coma which results directly from alcohol or drug use; or,*
- *A Diagnosis of brain death.*

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for:

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or,*
- *Non-surgical procedures.*

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

The Diagnosis of Deafness must be made by a Specialist.

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

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

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

The Diagnosis of Heart Attack must be made by a Specialist.
Exclusions: No benefit will be payable under this condition for:

- *ECG changes suggestive of a prior myocardial infarction;*
- *Other acute coronary syndromes, including angina pectoris and unstable angina; or*
- *Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.*

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for

- *Angioplasty;*
- *Inter-arterial procedures, percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

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

The Diagnosis of Kidney Failure must be made by a Specialist.

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

The Diagnosis of Loss of Limbs must be made by a Specialist.

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

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of

the survival period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

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

The Diagnosis of the major organ failure must be made by a Specialist.

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

The Diagnosis of Motor Neuron Disease must be made by a Specialist.

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

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

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

For purposes of the Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- *Solitary sclerosis;*
- *Clinically isolated syndrome;*
- *Radiologically isolated syndrome;*
- *Neuromyelitis optica spectrum disorders; or*
- *Suspected multiple sclerosis or probable multiple sclerosis.*

1-Year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last Reinstatement Date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the Diagnosis is made; or*
- *A Diagnosis of multiple sclerosis (covered or not covered under the Policy).*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

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

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

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

The Diagnosis of Occupational HIV Infection must be made by a Specialist.
Exclusion: No benefit will be payable under this condition if:

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

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

The Diagnosis of Paralysis must be made by a Specialist.

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

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination;

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For purposes of the Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this covered condition for:

- *Transient Ischaemic Attacks;*
- *Intracerebral vascular events due to trauma;*
- *Ischaemic disorders of the vestibular syndrome;*
- *Death of tissue of the optic nerve or retina without total loss of vision of that eye; or*
- *Lacunar infarcts which do not meet the definition of stroke as described above.*

DEFINITIONS OF COVERED CONDITIONS – EMPLOYEES AND SPOUSES ONLY

Dementia, including Alzheimer's Disease means a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The Insured Person must exhibit:

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

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

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

Loss of Independent Existence means a definite Diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already have been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of primary Parkinson's Disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease. Specified Atypical Parkinson's Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist.

1-Year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or*
- *A Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

DEFINITIONS OF ADVANCECARE BENEFIT CONDITIONS – EMPLOYEES AND SPOUSES ONLY

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer refers to one of the following conditions:

- Malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastrointestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- Ductal Carcinoma in situ of the Breast.

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

DEFINITIONS OF COVERED CONDITIONS – DEPENDENT CHILDREN ONLY

Cerebral Palsy means a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Congenital Heart Disease means a Diagnosis of one of the following heart conditions following a 30 day survival period from Diagnosis or birth, whichever comes later. The Diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

- Atresia of any heart valve
- Coarctation of the Aorta
- Double Inlet Ventricle
- Double Outlet Left Ventricle
- Ebstein’s Anomaly
- Eisenmenger Syndrome
- Hypoplastic Left Heart Syndrome
- Hypoplastic Right Ventricle
- Single Ventricle
- Tetralogy of Fallot
- Total Anomalous Pulmonary Venous Connection
- Transposition of the Great Vessels
- Truncus Arteriosus

Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded. All other congenital cardiac conditions are excluded.

Cystic Fibrosis means a definitive Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down Syndrome means a definitive Diagnosis of Down Syndrome supported by chromosomal evidence of Trisomy 21.

Muscular Dystrophy means a definitive Diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Type 1 Diabetes means a Diagnosis of type 1 mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a qualified pediatrician or endocrinologist licenced and practicing in Canada or the United States of America and there must be evidence of dependence on insulin for a minimum of three months.

CLAIMS AT TUGO

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. **Claims at** TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons at special pricing discounts.

For assistance in accessing this service, please visit **www.tugo.com/tms**.

Note that utilization fees may apply.

GENERAL PROVISIONS

Termination of Your Insurance

An Insured Employee's insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;

b) the date of death of the insured Employee;

c) the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for insurance under the Group Policy;

d) the date an Employee, under age 65 and residing in Québec, is no longer covered under a private drug plan provided by the Policyholder, as required by the Québec Act respecting prescription drug insurance;

e) the date of the Employee's 75th birthday;

f) the due date of any unpaid premiums;

g) the end of the month coincident with or next following the date the Administrator receives written notice from the Employee requesting cancellation of all or part of the insurance; and

h) the date on which a leave of absence has expired, and the Employee is not actively at work.

An Insured Spouse's insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;

b) the date of death of the Employee or Insured Spouse;

c) the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for insurance under the Group Policy;

d) the date of the Spouse's 75th birthday;

e) the due date of any unpaid premiums;

f) the end of the month coincident with or next following the date the Administrator receives written notice from the Employee requesting cancellation of all or part of the Spouse's insurance;

g) the date on which a leave of absence has expired, and the Employee is not actively at work; and

h) the date on which he/she no longer qualifies as a Spouse.

The Dependent Child Critical Illness Insurance in respect of an Insured Dependent Child will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;

b) the date that the Dependent Child Covered Condition Benefit is paid with respect to that Insured Dependent Child;

c) the date of death of the insured Employee or Insured Dependent Child;

d) the date all of the Insured Employee's Voluntary Group Critical Illness Insurance terminates;

e) the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for Dependent Child Critical Illness Insurance under the Group Policy;

f) the date of the Employee's 75th birthday;

g) the due date of any unpaid premiums;

h) the end of the month coincident with or next following the date the Administrator receives written notice from the Employee requesting cancellation of the Dependent Child Critical Illness Insurance coverage;

i) the date on which a leave of absence has expired, and the Employee is not actively at work; and

j) the date on which an Insured Dependent Child no longer qualifies as a Dependent Child.

Important note regarding termination of your coverage:
You must advise our office in writing once you, your Insured Spouse, and/or your Insured Dependent Child(ren) are no longer eligible for coverage under the Group Policy, if applicable.

Depending on when the Company is advised, the premium payor may be eligible to receive a premium refund of up to 3 months, if applicable.

CLAIMS PROCEDURES

Before paying a benefit under the Group Policy, we will require our claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at: 1.800.266.5667 to obtain the appropriate forms and for details on claims procedures.

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. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims will be adjudicated according to the definition of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

QUESTIONS? WE'RE HERE TO HELP.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
SpecialMarkets@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400 - 988 W Broadway PO Box 5900
Vancouver, BC V6B 5H6
Or visit our website at:
www.ia.ca

Employee Assistance Program (EAP)

Insurer

This benefit is provided by TELUS Health

TELUS Health is our Employee Assistance Program (EAP) provider. The EAP program offers a wide range of confidential and professional counselling, support and informational services. The coverage is available for you, your eligible spouse/partner and your eligible dependents.

There are many ways to get help today. You and your eligible family members can receive support over the telephone, in person, online, and through a variety of health and wellness resources. For each concern you are experiencing, you can receive a series of private sessions with an expert. You can also take advantage of online tools to help manage your and your family's health. You'll get practical and fast support in a way that is most suited to your preferences, learning preference and lifestyle.

Your EAP is completely confidential within the limits of the law. No one, including your employer, will ever know that you have used the program unless you choose to tell them.

There is no cost to you or your family to use your EAP. This benefit is provided to you by your employer. Your EAP can provide a series of sessions with a professional and if you need more specialized or longer-term support, a team of experts can suggest an appropriate specialist or service that is best suited to your needs. While fees for these additional services are your responsibility, they may be covered by your extended healthcare plan.

Contact TELUS Health at 1-844-880-9142, 24 hours a day / 7 days a week / 365 days a year. Your EAP offers several professional consultation and information services, which address a more specialized range of concerns. These include:

Resources and Support
- Separation and divorce
- Elder care
- Relationship conflict
- Parenting
- Blended family issues
- Maternity/parental leave
- Adoption
- Child care services
- Schooling
- Adult day programs
- Nursing and retirement homes
- Work-life balance
- Conflict
- Career planning
- Bullying and harassment

Achieve well-being
- Stress
- Depression
- Anxiety
- Anger
- Crisis situations
- Life transitions

Legal support services
- Separation and divorce
- Civil litigation
- Custody/child support
- Wills/estate planning

Financial support
- Credit and debt management
- Budgeting
- Bankruptcy
- Financial emergencies
- Changing circumstances

Nutrition support
- Weight management
- Boost energy and resilience
- High cholesterol
- High blood pressure
- Diabetes
- Heart disease

Focus on your health
- Identify conditions
- Prevent illness
- Manage symptoms
- Natural healing strategies
- Plan for better health

Tackle addictions
- Alcohol
- Tobacco
- Drugs
- Gambling
- Other addictions
- Post-recovery support

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).

Life's brighter under the sun

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

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Sun Life Financial