

your **group**
benefits



Seasonal employees

**Contract Number 100793, BSC 910 77 96 A
and PAI 910 77 97 A
Effective January 1, 2014**

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Benefit Details

In this section, you will find the options which are available under each benefit (*you are covered under the Option as outlined in your Benefit Summary*). For more information on each benefit, please refer to the appropriate section in this booklet.

The information contained in this section applies only to benefits insured by Sun Life of Canada.

Your Extended Health Care options

	Option 1	Option 2	Option 3
<i>Prescription drugs</i>	100% with drug card plan	80% with drug card plan	100% after the deductible, with drug card plan
<i>Prescription drug deductible</i>	None	None	The deductible is equal to the dispensing fee for each prescription or refill.
<i>Drug substitution limit</i>	Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.	Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.	Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.
<i>Hospital expenses in your province</i>	100% semi-private room		
<i>Convalescent hospital</i>	100% of expenses payable		
<i>Expenses out of your province</i>	Semi-private hospital room All other expenses, up to the reasonable and usual rates in the locality where the services or supplies are provided		

	Option 1	Option 2	Option 3
<i>Medi-Passport</i>	Covered		
<i>Medical services and equipment</i>	100% of expenses payable		
<i>Paramedical services</i>	100% of expenses payable		
<i>Vision care</i>	100% of expenses payable		
<i>Benefit year</i>	January 1 to December 31		
<i>Coverage ends</i>	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .		

Your Dental Care options

	Option 1	Option 2
<i>Preventive</i>	80%	80%
<i>Basic</i>	80%	80%
<i>Major</i>	Not covered	70%
<i>Benefit year maximum</i>	\$1,000 for Preventive and Basic combined	Unlimited for Preventive and Basic. \$1,500 for Major
	If your coverage starts in the second half of a benefit year, the maximum amount for that benefit year will be reduced by 50%.	
<i>Benefit year</i>	January 1 to December 31	
<i>Coverage ends</i>	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .	

Your Basic Life coverage

<i>Coverage</i>	Flat \$50,000
<i>Coverage ends</i>	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

Basic Life coverage for your dependents

	Core	Option 1
<i>Child coverage</i>	\$2,500	\$5,000
<i>Spouse coverage</i>	\$5,000	\$10,000
<i>Proof of good health</i>	Not required	
<i>Coverage ends</i>	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .	

Your Optional Life coverage

<i>Coverage</i>	As elected by the employee, units of \$10,000
<i>Maximum</i>	\$200,000
<i>Proof of good health</i>	Required on all optional amounts
<i>Coverage ends</i>	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

Optional Life coverage for your spouse

<i>Coverage</i>	As elected by the employee, units of \$10,000
<i>Maximum</i>	\$200,000
<i>Proof of good health</i>	Proof of good health of your spouse is required
<i>Coverage ends</i>	When you retire or reach age 65, or when your spouse reaches age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

General Information

The information contained in this section applies only to benefits insured by Sun Life of Canada.

About this booklet

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

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

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

Eligibility

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

- you are actively working for your employer at least 30 hours a week.
- you work for a least 3 consecutive months per year.
- you have completed the waiting period.

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

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to

Who qualifies as your dependent

3 months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

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

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, is an eligible dependent. You can only cover one spouse at a time.

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

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

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

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

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

Enrolment

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

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

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

There are other cases when you will be required to provide proof of good health. Your employer will let you know when this is necessary.

When coverage begins

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

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

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

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

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

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

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

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

Accessing your records

As required by legislation, for insured benefits, if you reside in Alberta or British Columbia, you may obtain copies of the following documents:

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

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

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

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

- our Sun Life Financial Plan Member Services website at www.mysunlife.ca.
- our Sun Life Financial Customer Care centre by calling toll-free at 1-800-361-6212.

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

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

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

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

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

However, for the Extended Health Care benefit, if you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following dates:

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

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim, or
- regarding claims for *Coverage during total disability* which are initially approved, more than one year after the date you cease to be covered or your premiums cease to be waived.

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Seasonal employees* All employees other than seasonal employees of the Town of Grand Falls – Windsor.
- Illness* An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.
- Retirement date* If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.
- We, our and us* We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care (Medicare Supplement)

Insurer	<i>This benefit is insured by Sun Life of Canada.</i>
General description of the coverage	<p>In this section, <i>you</i> means the employee and all dependents covered for Extended Health Care benefits.</p> <p>Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.</p>
Benefit year	The benefit year is indicated in the Benefit Details section.
Deductible	<p>The deductible is the portion of claims that you are responsible for paying.</p> <p>For prescription drugs the deductible is indicated under each option in the Benefit Details section.</p> <p>For other expenses, there is no deductible.</p>
Prescription drugs	<p>We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.</p> <ul style="list-style-type: none">■ drugs that legally require a prescription.■ life-sustaining drugs that may not legally require a prescription.

- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility, up to a lifetime maximum of \$2,400 for each person.
- vaccines that legally require a prescription.
- intrauterine devices (IUDs) and diaphragms.
- varicose vein injections.

We will cover the cost of the above drugs and supplies as indicated under each option in the Benefit Details section.

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- products to help you quit smoking.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural

Product Number (NPN).

- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

***Drug substitution
limit***

The drug substitution limit is indicated in the Benefit Details section.

***Other health
professionals allowed
to prescribe drugs***

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

**Hospital expenses in
your province**

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

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

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as:

- it follows at least 5 consecutive days of in-patient hospitalization,
- it begins within 14 days of release from the hospital, and
- it is primarily for rehabilitation.

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

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

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

Expenses out of your province

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

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

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

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

Emergency services

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

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

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

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

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

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

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

***Emergency services
excluded from
coverage***

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.

- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

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

All referred services must be:

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

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

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

Non-emergency transportation expenses

We will cover travel expenses for you or your dependent when the distance travelled is at least 200 kilometres, round-trip. The medical services must be prescribed by a doctor and not available in your area. Payment is based on the most economical means of transportation. Any expenses incurred for cosmetic purposes or for dental treatment are not covered. Confirmation that treatment was rendered is also required.

We will also cover the cost of escort expenses for a child who is under the age of 19 or mentally or physically handicapped or for a medical

escort when deemed necessary by the Attending Physician.

The maximum amount payable is:

- \$0.50 per kilometre, for a private vehicle.
- \$25 a day for each person required to travel for meals.
- \$75 a day for accommodations.

Overall maximum We will not pay more than \$700 per round-trip for residents of Labrador and \$500 for all other residents.

Benefit year maximum We will not pay more than \$2,000 per person for all travel expenses.

NOTE Receipts are required for all expenses other than mileage claims.

Medical services and equipment We will cover 100% (50% for insulin pumps) of the costs for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

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

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

- laboratory tests performed by a commercial laboratory for the diagnosis of an illness. Tests performed in a doctor's office or pharmacy are not covered.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 6 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, up to a maximum of 1 examination in any 12 month period for a person under age 19 or in any 24 month period for any other person.
- wigs following chemotherapy, up to a maximum of \$300 per person in a benefit year. Wigs do not require a doctor's order.
- equipment rented, or purchased at our request, that is for temporary therapeutic use. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- external breast prostheses required as a result of surgery, up to a maximum of 1 prostheses per breast in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes, excluding myoelectric appliances.

- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of \$350 per person in a benefit year.
- orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum 1 pair per person in a benefit year.
- hearing aids prescribed by a doctor, up to a maximum of \$300 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of \$350 per person.
- 50% of the cost of insulin pumps, when prescribed by an endocrinologist.
- colostomy supplies.

Paramedical services

We will cover 100% of the costs, up to a combined maximum of \$1,500 per person per benefit year for all paramedical specialists listed below:

- licensed psychologists.
- licensed massage therapists, when ordered by a doctor.
- licensed speech therapists.

- licensed physiotherapists.
- licensed naturopaths.
- licensed acupuncturists.
- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, podiatrists or chiropodists, including a maximum of one x-ray examination per specialty each benefit year.

Contact lenses, eyeglasses or laser eye correction surgery

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

We will cover 100% of these costs up to a maximum of \$150 in any 12 month period for a person under age 19 or in any 24 month period for any other person.

We will also cover 100% of the costs of contact lenses prescribed for the treatment of severe corneal astigmatism, severe corneal scarring, keracotonus or aphakia, if visual acuity in the better eye cannot be improved to at least 20/40 with eyeglasses, up to a lifetime maximum of \$250.

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

My Health CHOICE coverage

If your coverage under this plan terminates because your employment has ended, you may purchase Sun Life's My Health CHOICE coverage. This coverage is different from your group plan.

To be eligible for My Health CHOICE coverage, you must:

- apply for My Health CHOICE coverage within 60 days after the termination of your coverage,
- be under age 75 on the date you apply, and

- be a resident of Canada and be covered under the provincial health plan.

My Health CHOICE coverage may also include Dental coverage if you were covered for both Extended Health Care and Dental Care benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependents if those family members were covered under your group plan. Your spouse must be under age 75 on the date you apply for this coverage.

From time to time, Sun Life may review the eligibility requirements and, on the date you apply for My Health CHOICE coverage, they may be different from those listed in this booklet.

To apply for My Health CHOICE or if you have any questions, please call our Customer Solutions Centre at 1-877-893-9893.

Payments after coverage ends

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

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

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

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, as if the benefit were still in effect.

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

-
- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
 - services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
 - equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
 - any services or supplies that are not usually provided to treat an illness, including experimental treatments.
 - services or supplies for which no charge would have been made in the absence of this coverage.
 - delivery and transportation charges.

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

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

**Integration with
government
programs**

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

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

- whether you have made an application to the government

program,

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

When and how to make a claim

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

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

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

Emergency Travel Assistance

Insurer

This benefit is insured by Sun Life of Canada.

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (*Europ Assistance*) can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Europ Assistance. If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has

the right to deny or limit payments for all expenses related to that emergency.

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

Europ Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

mentally or physically handicapped.

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

- Limits on advances** Advances will not be made for requests of less than \$200. Requests in excess of \$200 will be made in full up to a maximum of \$10,000.
- The maximum amount advanced will not exceed \$10,000 per person per trip unless this limit will compromise your medical care.
- Reimbursement of expenses** If, after obtaining confirmation from Europ Assistance that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.
- To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.
- Your responsibility for advances** You will have to reimburse Sun Life for any of the following amounts advanced by Europ Assistance:
- any amounts which are or will be reimbursed to you by your provincial medicare plan.
 - that portion of any amount which exceeds the maximum amount of your coverage under this plan.
 - amounts paid for services or supplies not covered by this plan.
 - amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.
- Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.
- Limits on Emergency Travel Assistance coverage** There are countries where Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.
- Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:
- a rebellion, riot, military up-rising, war, labour disturbance,

strike, nuclear accident or an act of God.

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

**Liability of Sun Life
or Europ Assistance**

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

Dental Care

Insurer

This benefit is insured by Sun Life of Canada.

General description of the coverage

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

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

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

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide approved by the provincial Dental Association for that specialist will be used.

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

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

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

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

Benefit year	The benefit year is indicated in the Benefit Details section.
Benefit year maximum	The maximum amount we will pay per person per benefit year is indicated under each option in the Benefit Details section.
Predetermination	We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.
Preventive dental procedures	<p>Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.</p> <p>The reimbursement level is indicated under each option in the Benefit Details section.</p>
<i>Oral examinations</i>	<p>1 complete examination every 24 months.</p> <p>1 recall examination every 5 months, up to a maximum of 2 examinations per benefit year.</p> <p>Emergency or specific examinations.</p>
<i>X-rays</i>	<p>1 complete series of x-rays or 1 panorex every 24 months.</p> <p>1 set of bitewing x-rays every 5 months, up to a maximum of 2 sets per benefit year.</p> <p>X-rays to diagnose a symptom or examine progress of a particular</p>

course of treatment.

Other services Required consultations between two dentists.

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

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth and habit breaking appliances.

Pit and fissure sealants.

Basic dental procedures

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

The reimbursement level is indicated under each option in the Benefit Details section.

Fillings Amalgam, composite, acrylic or equivalent.

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

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

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

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

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

<i>Rebase or reline</i>	Rebase or reline of an existing partial or complete denture.
Major dental procedures (Option 2 only)	<p>Your dental benefits include the following procedures used to treat major dental problems.</p> <p>The reimbursement level is indicated under each option in the Benefit Details section.</p>
<i>Major restorations</i>	Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (<i>Basic dental procedures</i>).
<i>Repair</i>	Repair of bridges or dentures.
<i>Prosthodontics</i>	<p>Construction and insertion of bridges or standard dentures. Coverage is limited to teeth extracted while you are covered under this plan. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:</p> <ul style="list-style-type: none"> ■ it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition. ■ it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.
Payments after coverage ends	If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.
What is not covered	We will not pay for services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees, extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.

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

We will not pay for:

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

We will also not pay for dental work resulting from:

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

**When and how to
make a claim**

- participation in a criminal offence.

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

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

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

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

Life Coverage

Insurer	<i>This benefit is insured by Sun Life of Canada.</i>
General description of the coverage	<p>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.</p> <p>The amounts of coverage are indicated in the Benefit Details section.</p>
Who we will pay	<p>If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.</p> <p>If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.</p> <p>If a dependent dies, Sun Life will pay you the benefit for that dependent.</p> <p>For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file. If you have not named a beneficiary, the benefit amount will be paid to you.</p> <p>A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.</p>
Suicide	<p>If you or your spouse have any optional coverage that has been in</p>

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

Coverage during total disability

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

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

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

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

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

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

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

Converting Life coverage

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

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

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

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

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

When and how to make a claim

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

Accidental Death and Dismemberment

Insurer

This benefit is insured by Chartis Insurance Company of Canada.

General

Your employer has provided for you Basic Accident Insurance coverage. And your employer is also offering you through the benefit of group buying power, the opportunity to purchase simple and affordable Voluntary Accident Insurance coverage. Both plans are underwritten by Chartis Insurance Company of Canada.

Basic Accident Insurance plan BSC 910 77 96 A

How It Works

You are automatically covered if you are employed by a member municipality of the Policyholder and are insured under the Basic Life Insurance.

Principal Sum

Amount equal to Basic Life Insurance benefit.

Age termination (Basic Accident Insurance)

Same as your Basic Group Life insurance.

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-

clock—at work, at home or at play, anywhere in the world.

Voluntary Accident Insurance plan PAI 910 77 97 A

How It Works

You choose a Principal sum amount for yourself and your eligible Dependents, which is set out on your application to enroll. You are eligible to enroll if you belong to one of the following classes:

Class I: Active eligible Employees of the Policyholder.

Class II: All Class I Employees, their Spouses and eligible Dependent Children.

For a Principal amount of:

Class I: a minimum of \$ 10,000 and a maximum of \$ 250,000 in units of \$ 10,000.

Class II: a minimum of \$ 10,000 and a maximum of \$ 250,000 in units of \$10,000.

If the insured Employee enrolls for Family coverage and the Insured has:

- a) a spouse only with no Dependent Children, the Spouse's Principal sum is 60% of the Insured Employee's Principal sum; or
- b) a spouse with Dependent Children, the spouse's Principal sum is 50% of the Insured Employee's Principal sum and each Dependant Child's Principal sum is 15% of the Insured Employee's Principal sum; or
- c) dependent Children with no spouse, each Dependant child's Principal sum is 20% of the Insured Employee's Principal sum.

Enrolling is Easy

You're eligible to enroll if you are a member municipality of the Trio

Benefits program or elected official and employed on a permanent basis. To include your dependent family members for coverage, select the family plan option.

To learn more about this valuable benefit offering or if you're ready to enroll, contact your Human Resources Department today.

Age termination (Voluntary Accident Insurance)

When you retire or reach the age 75 (Employee and Spouse), whichever is earlier. For Dependent Children, please refer to Definition of Dependent Children.

Please note

Here's What You Get

Broad Accident Insurance Coverage - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Amount of Coverage Available - You select the amount of coverage amount you need from a minimum of \$10,000 up to a maximum of \$250,000 in coverage, not to exceed 10 times salary.

Guaranteed Acceptance - Coverage is provided regardless of your health history.

24/7 Worldwide Coverage - Your coverage is in force around-the-clock - at work, at home or at play, anywhere in the world.

Economical Cost - Group buying power allows you to purchase coverage at reduced rates, well below that of an individual policy.

Convenient Payroll Deductions - For your convenience, the insurance premiums are automatically deducted.

Basic AND Voluntary Accident Insurance plans:

Definitions

"Insured Employee" means you, if you are a permanent employee of the Policyholder.

“**Spouse**” means a person, who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

“**Dependent Child**” means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the benefit will be paid to the beneficiary you have designated in writing under your employer’s current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of losses

Loss of life.....	The Principal Sum
Loss of both hands or both feet.....	The Principal Sum

Loss of entire sight of both eyes.....	The Principal Sum
Loss of one hand and one foot.....	The Principal Sum
Loss of one hand and the entire sight of one eye.....	The Principal Sum
Loss of one foot and the entire sight of one eye.....	The Principal Sum
Loss of one arm or one leg.....	Four-fifths of the Principal Sum
Loss of one hand or one foot.....	Three-quarters of the Principal Sum
Loss of the entire sight of one eye.....	Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand...	One-third of the Principal Sum
Loss of speech and hearing.....	The Principal Sum
Loss of speech or hearing.....	Three-quarters of the Principal Sum
Loss of hearing in one ear.....	Two-thirds of the Principal Sum
Loss of four fingers of one hand.....	One-third of the Principal Sum
Loss of all toes of one foot.....	One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands.....	The Principal Sum
Loss of use of one hand or one foot.....	Three-quarters of the Principal Sum
Loss of use of one arm or one leg.....	Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs).....	Two times The Principal Sum up to a maximum of one million dollars
Paraplegia (total paralysis of both lower limbs).....	Two times The Principal Sum up

	to a maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body).....	Two times The Principal Sum up to a maximum of one million dollars

"Loss" when used with reference to "Quadriplegia", "Paraplegia", and "Hemiplegia" means the complete and irreversible paralysis of such limbs; "Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; "Arm" or "Leg" means the complete severance through or above the elbow or knee joint; "Thumb and Index Finger" means the complete severance through or above the first phalange; "Fingers" means the complete severance through or above the first phalange of all Four Fingers of One Hand; "Toes" means the complete severance of both phalanges of all the Toes of One Foot; "The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; "The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; "Hearing in One Ear" means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Hearing" means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Speech" means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. "Loss" when used herein may also include "Loss of Life".

Indemnity provided under this section for all losses sustained by any

one Insured Person as the result of any one accident will not exceed the Principal Sum with the exception of 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 but not to exceed a maximum total payment of \$1,000,000.

Permanent and Total Disability Indemnity

If you or your eligible insured dependents suffer injury causing Permanent and Total Disability, the Company shall pay the Principal Sum less any amounts under the Table of Losses which have been paid or which are payable for the same loss. Permanent and Total Disability means as a result of an injury, you or your eligible insured dependents are unable to perform at least two of the Activities of Daily Living described below without assistance from another person for 12 months after the date of the injury, and are then determined to be unable to perform such activities without assistance for the remainder of your life, and a physician certifies that your disability is total, permanent and irreversible.

Activities of Daily Living are:

1. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
5. Eating: performing all major tasks of getting food into the body; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower.

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of

\$15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to \$15,000 for modification to your home or vehicle if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

Psychological Therapy

Pays a benefit of up to \$5,000 if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of \$2,500 per month for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you or eligible insured dependents suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to \$15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to \$15,000 to cover the expenses to return your body to your city of residence if you or your eligible insured dependents suffer a covered accidental death while at least 50 kilometers from home.

Identification Benefit

Pays a benefit of up to \$5,000 for the transportation of an immediate

family member to identify your body if you or your eligible insured dependents suffer a covered accidental death at least 150 kilometers from home and a law enforcement agency requests such identification.

Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of \$50,000 if you or your eligible insured dependents suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

Day Care Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of \$5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of \$5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you or your insured Spouse suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit

Pays a benefit of up to \$15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense

Pays a benefit of up to \$5,000 to reimburse funeral expenses if you or your eligible insured dependents suffer a covered accidental death.

Bereavement Benefit

Pays a benefit of up to \$1,000 if you have selected single coverage and you suffer loss of life in a covered accident and your eligible

dependents require counseling within one year of the accident. Pays a benefit of up to \$2,000 if you have selected family coverage and an you or your eligible insured dependents suffer loss of life in a covered accident and you or your eligible dependents require counseling within one year of the accident.

Coma Benefit

Pays a monthly benefit of 1% of the difference between the Principal Sum and any other amount payable under the Plan in connection with the injury for up to 100 months, if you or your eligible insured dependents suffer an injury for which you receive a benefit under the Plan, and within 90 days of the date of the covered accident are disabled by coma which lasts for at least 6 consecutive months and is then determined by a physician to be permanent.

Child Enhancement Benefit (Voluntary Accident Insurance Plan Only)

With the exception of Loss of Life, all indemnities payable under this policy, are doubled with respect to Insured Dependent Child.

Common Disaster Benefit (Voluntary Accident Insurance Plan Only)

If you and your Insured Spouse both are injured in the same accident and both die within 90 days of the accident as a direct result of such injuries, your Spouse's Principal Sum amount will be increased to equal yours.

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Extended Family Coverage (Voluntary Accident Insurance Plan Only)

If you die, the coverage of your insured Spouse and/or insured Dependent Children will continue for up to 12 months, without premium paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- (a) suicide or any attempt thereat by you while sane;
- (b) self inflicted injury or any attempt thereat by you while sane or insane;
- (c) declared or undeclared war or any act thereof;
- (d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
- (e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
- (f) sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- (g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- (h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
 - I. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
 - II. performing, learning to perform or instructing others to

perform as a pilot or crew member of any aircraft; or

- III. riding as a passenger in an aircraft owned or leased by the Policyholder;
- (i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
 - (j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
 - (k) natural causes.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Effective Date

Your Basic Accident Insurance coverage begins on the date you satisfy the definition of "Insured Employee".

For the Voluntary Accident Insurance plan, the effective date of coverage is the first day of the month following the date that the signed application to enroll is received by the policyholder.

Termination Date

**Contract No. BSC 910 77 96 A
and PAI 910 77 97 A**

Accidental Death and Dismemberment

Coverage ends on the earliest of:

(1) the date the policy is terminated; (2) the premium due date if premiums are not paid when due; (3) the date you no longer satisfy the definition of an Insured Employee; or (4) the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by Chartis Insurance Company of Canada.

Respecting your privacy

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