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your group benefits

University of Northern British Columbia

Faculty Association employees

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

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 Customer Care representative for assistance with your coverage by calling toll-free at 1-866-881-0583.

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 SunLife Mobile App!

- Free from BlackBerry App World, the Apple App Store or Google Play, anytime (Other smartphone users can access my SunLife Mobile at m.mysunlife.ca)
- 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

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.

Your Travel Card

Provided by Sun Life 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 Allianz Global Assistance?

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

All other inquiries

Call 1-866-881-0583.

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 Accidental Death and Dismemberment benefit described later in this booklet is not insured or administered 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	The waiting period is: • 3 months of continuous employment for Dental Care • None all other benefits Any period during which you were working for the University of Northern British Columbia in another role will be counted as part of the waiting period
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 150560

Benefit year	November 1, 2016 to December 31, 2016, and then from January 1 to December 31
Deductible	For prescription drugs – $25 per benefit year per person, up to a maximum of $50 per family For other expenses – none
Reimbursement level	
Prescription drugs	80% after the deductible We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible • drugs and oral contraceptives that legally require a prescription • life-sustaining drugs that may not legally require a prescription • diabetic and colostomy supplies • injectable drugs and vitamins • allergy extract with a DIN and allergy serums • compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN

	• products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $500 per person • drugs for the treatment of infertility, up to a lifetime maximum of $2,400 per person • vaccines • varicose vein injections • anti-obesity drugs • drugs for the treatment of sexual dysfunction 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.
In-province hospital	80% of the difference between the cost of a ward and a semi-private room
Convalescent hospital	80% of the difference between the cost of a ward and a semi-private room up to a maximum of 180 days for treatment of an illness due to the same or related causes
Substance abuse rehabilitation centre	80% of the difference between the cost of a ward and a semi-private room up to a lifetime maximum of 60 days per person
Out-of-province emergency services	100% Emergency Travel Assistance included Maximum of 60 days per trip Per trip maximum of $5,000,000 per person for out-of-Canada services
Out-of-province referred services	80%
Medical services and equipment	80%
Paramedical services	80% up to a maximum of $500 per person per benefit year and a limit of $10 per visit for the first 12 visits per specialty for the qualified paramedical practitioners listed below: • massage therapists • physiotherapists • naturopaths or homeopaths • 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
Other paramedical services	80% up to a maximum of $500 per person per benefit year per specialty for the qualified paramedical practitioners listed below: • psychologists, social workers or clinical counsellors • speech therapists • acupuncturists • osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year • audiologists
Vision care	100% up to a maximum of $500 in any 12 month period for a person under age 19 or in any 24 month period for any other person
Termination	When you reach the traditional retirement date (TRD)

Dental Care - Contract Number 150560

Benefit year	November 1, 2016 to December 31, 2016, and then from January 1 to December 31

Deductible	None
Fee guide	The current fee guide for general practitioners in the province where the treatment is received
Reimbursement percentage	
Preventive procedures	100%
Basic procedures	100%
Major procedures	100%
Orthodontic procedures	65%, only for children under age 19
Maximum benefit	
Benefit year maximum	$1,500 per person A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime maximum	Orthodontic procedures – $3,000 per person
Termination	When you retire

Long-Term Disability - Contract Number 102060

Maximum amount	66.67% of the first $2,500 of your monthly basic earnings, plus 50% of the next $3,000, plus 35% of the balance of your monthly earnings, if any, up to a maximum benefit of $8,000 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
Elimination period	60 days
Maximum benefit period	The period ending on the last day of the month in which you reach the traditional retirement date (TRD). If you attain the traditional retirement date (TRD) while receiving benefits, benefits will continue until you have received a total of 15 weeks of combined payments from Salary Continuance and Long-Term disability or you are no longer totally disabled, whichever occurs first Benefits may also end on an earlier date as specified in the *Long-Term Disability* section of this booklet
Termination	When you retire or reach the traditional retirement date (TRD), whichever is earlier
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 102060

Employee Basic Life

Amount	2 times your annual basic earnings rounded to the next higher $1,000 Maximum – $500,000
Reduction	Coverage is reduced to 50% of the above amount when you reach age 70 If you continue, or begin, to work after having reached age 70, we calculate the amount for which you would have been eligible if you had not already reached age 70, then, we apply the above reduction clause to calculate the amount for which you are eligible.
Termination	When you retire or reach age 75, whichever is earlier

Employee Optional Life

Amount	You can choose coverage in units of $10,000 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 the traditional retirement date (TRD), whichever is earlier

Spouse Optional Life

Amount	You can choose coverage in units of $10,000 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 reach the traditional retirement date (TRD) or when your spouse reaches age 65, whichever is earlier

Making Claims

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

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

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information Sun Life needs.

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 Sun Life 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 Sun Life.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which you incur the expenses, or • 90 days after the end of your Extended Health Care coverage.
Emergency Travel Assistance	Contact Allianz Global Assistance to confirm that you are covered and a medical emergency exists.	**Having your expenses reimbursed:** To have Sun Life reimburse you for services or supplies you have paid for, you must provide proof of the expenses to us within 30 days of returning to the province where you live. Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.

Type of claim	Starting the claims process	Limits and special instructions
Dental Care	Ask Sun Life for the form to complete, or get the form on our website. Your dentist will have to complete a section of the form. You can also submit claims for some expenses electronically. For more information, ask Sun Life.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which you incur the expenses, 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, you will need to submit a treatment plan to Sun Life.
Long-Term Disability	To make a claim, complete the claim forms available from your employer. Ensure that the following people complete them: • you • your attending doctor • your employer. The submission of these forms is your proof of claim.	You should submit your proof of claim at least 4 weeks prior to the completion of your elimination period, but in no event later than 90 days after the end of your elimination period. If your Long-Term Disability coverage terminates, you must advise Sun Life 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, Sun Life 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 Sun Life 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 Accidental Death and Dismemberment benefit described later in this booklet is not insured or administered 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 contract with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

The 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 Sun Life.

Your group benefits	The contract holder, University of Northern British Columbia, self-insures the following benefits: • Extended Health Care • Emergency Travel Assistance • Dental Care This means University of Northern British Columbia has the sole legal and financial liability for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.
Who is eligible to receive benefits?	To be eligible for group benefits, you must live in Canada and meet all the following conditions: • you are a permanent employee working in Canada. • you are an active full time employee working at least 51% of a full-time equivalent as defined in the collective agreement, if applicable. • you have completed the waiting period indicated in the Benefit Summary. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent You must apply for coverage for yourself in order for your dependents to be eligible.
Who qualifies as your dependent	Your dependent must be: • your spouse or your child, and • living in Canada or the United States. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage • under any other formal union recognized by law • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least the last 1 year You can only cover one spouse at a time.

	Your children and your spouse's children (other than foster children) are eligible dependents if they are under age 19 and do not have a spouse. A child who is a full-time student until age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse. **If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask Sun Life for more on this.**
How to enrol	*For you* – You must provide the proper enrolment information to Sun Life. *For a dependent* – You must ask for dependent coverage. If you or your dependents already have similar Extended Health Care or Dental Care coverage under this or another plan – You may refuse this coverage under this plan. If the other coverage ends at a later date, you can enrol for coverage under this plan then. You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health. • Employee Optional Life • Spouse Optional Life
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 your spouse's Optional Life coverage would normally begin, then that coverage will not begin until you return to active work with your employer.
Changes affecting your coverage	If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health. If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to Sun Life: • 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 1-866-881-0583.
When coverage ends	As an employee, your coverage will end on the earlier of the following dates: • the date your employment ends or you retire. • the date you are no longer actively working. • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends. A dependent's coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage. The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

If you die while covered by this plan

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

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

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

The continuation of coverage does not apply to the spouse's 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 eligible expenses.

However, when you have more than one plan, industry standards decide which plan you should claim expenses from first.

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

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

When you send us a claim, you must tell Sun Life 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 benefit.

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.

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.
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 Traditional Retirement Date (TRD), unless you have actually retired before then.
Salary Continuance	The contract holder's internal Salary Continuance program
Traditional Retirement Date (TRD)	If your 65th birthday occurs January 1 – June 30, the TRD is the 30th of June coinciding with or next following your 65th birthday. If your 65th birthday occurs July 1 – December 31, the TRD is the 31th of December coinciding with or next following your 65th birthday

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.

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

Reasonable and customary charges mean:

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

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

Claiming when the expense is incurred	You must claim any 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.
Deductible and reimbursement level	The deductible is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the deductible and the reimbursement level are 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 100 day period.

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.

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 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.
Substance abuse rehabilitation centre	We will cover the cost for the treatment of alcohol or drug abuse in a licensed substance abuse rehabilitation centre, as indicated in the Benefit Summary.

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 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 provider, AZGA Service Canada Inc. (*Allianz Global Assistance*) right away. Allianz Global Assistance must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them. **If Allianz Global Assistance 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 Allianz Global Assistance cannot be made before services are provided, you must contact Allianz Global Assistance as soon as possible afterwards. An emergency ends when Allianz Global Assistance, 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 Allianz Global 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. 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	$10,000 per person per benefit year
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*	

Covered expenses	Details	Payment limits
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	PSA (prostate-specific antigen) tests are limited to $15 per person per benefit year 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 90 days of the accident or a treatment plan must be received and approved within 90 days 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
Ophthalmologist or licensed optometrist	Services of an ophthalmologist or licensed optometrist	1 exam and a maximum of $65 per person in any 24 month period
Contact lenses or intraocular lenses	After cataract surgery	
Lenses prescribed for the treatment of keratoconus		
Wigs	After chemotherapy	$500 per person, per lifetime
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	$200 per person per benefit year
Surgical brassieres	Required as a result of surgery	4 brassieres per person per benefit year
Artificial limbs and eyes		Myoelectric appliances are not covered
Stump socks		5 pairs per person per benefit year

Covered expenses	Details	Payment limits
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	4 pairs per person per benefit year
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair and a maximum of $300 per person per benefit year
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair and a maximum of $250 per person per benefit year
Hearing aids		$400 per person over 5 benefit years Repairs are included in this maximum Batteries are not covered
Oxygen		
Blood glucose monitors		$700 per person, per lifetime
Insulin pumps	Must be prescribed by a doctor	
intrauterine devices (IUDs), diaphragms, contraceptive patches and contraceptive delivery systems	Must be prescribed by a doctor	
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 Sun Life.

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.

Covered expenses	Details	Payment limits
Vision care		
Contact lenses, eyeglasses 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

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 Sun Life considers 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 your employer's 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.

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 AZGA Service Canada Inc. (*Allianz Global Assistance*) right away.
	If Allianz Global Assistance 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 Allianz Global Assistance cannot be made before services are provided, you must contact Allianz Global Assistance 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. Allianz Global Assistance may arrange for:
On the spot medical assistance	Allianz Global Assistance will provide referrals to physicians, pharmacists and medical facilities. As soon as Allianz Global Assistance is notified that you have a medical emergency, its staff, or a physician designated by Allianz Global 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, Allianz Global Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

	Allianz Global Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel. Allianz Global Assistance will transmit an urgent message from you to your home, business or other location. Allianz Global Assistance will keep messages to be picked up in its offices for up to 15 days.
Transportation home or to a different medical facility	Allianz Global 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, Allianz Global Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation. Sun Life or Allianz Global 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, Allianz Global 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. Allianz Global 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 Allianz Global 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	Allianz Global 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 (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, Allianz Global Assistance 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	Allianz Global 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 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, Allianz Global Assistance 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	Allianz Global Assistance 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, Allianz Global Assistance 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, after obtaining confirmation from Allianz Global Assistance 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 Allianz Global Assistance. Allianz Global Assistance'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 1-866-881-0583. Allianz Global Assistance 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 Allianz Global Assistance 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 Allianz Global 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.

Limits on Emergency Travel Assistance coverage	There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before you leave on your trip. Allianz Global Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: • rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or an act of God. • refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.
Liability of Sun Life or Allianz Global Assistance	Neither Sun Life nor Allianz Global 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

Plan administrator

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

General description of the coverage

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

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

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

For each dental procedure, we will only cover **reasonable expenses**. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

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

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

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

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

For an implant related crown or prosthesis	We will pay the benefit that would have been payable under this plan for a tooth supported crown or a non-implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. **All other expenses related to implants, including surgery charges, are not covered.**
If you receive any temporary dental service	It will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.
Claiming when the expense is incurred	You must claim any 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.

Deductible and reimbursement percentage	The deductible is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan. **The deductible and the reimbursement percentages are indicated in the Benefit Summary**.
Maximums	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.

Look for your deductible, reimbursement percentage and maximum amount for each type of service in the Benefit Summary section at the beginning of this booklet.

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 24 months. • 1 recall examination every 6 months. • emergency or specific examinations.
X-rays	• 1 complete series of x-rays every 24 months. • 1 panorex every 24 months. • 1 set of bitewing x-rays every 6 months. • x-rays to diagnose a symptom or examine progress of a certain course of treatment.
Other services	• required consultations between two dentists. • consultations between patient and dentist. • polishing (cleaning of teeth) and topical fluoride treatment once every 6 months. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth and related anaesthesia. • providing space maintainers for missing primary teeth. • pit and fissure sealants, to a maximum of one treatment per tooth every 24 months.
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.
Periodontics	• treating disease of the gum and other supporting tissue. • scaling and root planing, up to a combined maximum of 12 units of 15 minutes per benefit year. • occlusal equilibration, up to a maximum of 8 units of 15 minutes per benefit year.
Oral surgery	• surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).
Major dental procedures – Your dental benefits include the following procedures used to treat major dental problems.	
Major restorations	• inlays and onlays. Replacements must be separated by at least 12 months.
	• crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*). Replacements must be separated by at least 12 months.
Repair of bridges	• repair of bridges.
Repair of dentures	• repair of dentures.
Rebase or reline	• rebase or reline of an existing partial or complete denture.
Prosthodontics	Construct and insert bridges or standard dentures, limited to teeth extracted while a person is covered under this provision. 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.
Orthodontic procedures – Your dental benefits include the following procedures used to treat misaligned or crooked teeth. **Only persons under the maximum age indicated in the Benefit Summary are covered for these procedures.**	
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.

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 terminates, we will still cover you for procedures to repair natural teeth damaged by an accidental blow:

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

What is not covered

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

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

We will not pay for:

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

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 the same employer or with another employer.
- 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 or other salary continuation plan. 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, for 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. • 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 basic earnings 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 are eligible for any of the benefits or payments described above and do not apply for them, we will still consider them. We can estimate those benefits and payments and use them when we calculate your Long-Term Disability payments.
- 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 occurs again (reoccurs) due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 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 basic earnings 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 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 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.

When coverage ends

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

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 spouse's Life coverage provides a benefit if your spouse 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, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life. If you have not named a beneficiary, 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. For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, we will pay the benefit amount to you. **Fact** There are different rules for designating a minor beneficiary, please refer to your contract for specific information.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, while sane or insane.
Coverage during total disability	Life coverage may continue without the payment of premiums if you become totally disabled before you reach your Traditional Retirement Date (TRD), 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 Sun Life for details.

Converting Life coverage

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

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 Sun Life for details.

Basic and Voluntary Accidental Death and Dismemberment

Insurer

This benefit is insured by CHUBB

BASIC ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

COVERAGE

This benefit is payable, in addition to any other insurance benefits, for paralysis, loss of life, limb, sight, speech or hearing which is the result of accidental bodily injuries and which occur within 365 days from the date of the accident.

This coverage applies 24 hours a day, 365 days a year, on or off the job, anywhere in the world, including while travelling (passenger only) in commercial or chartered aircraft.

ELIGIBILITY

You will be eligible for insurance if you are a faculty member of the Policyholder, who is under the age of 75, and who regularly works no less than 18 hours per week.

Contract employee" means an individual who has a written contract with the Policyholder and works exclusively for the Policyholder no less than 18 hours per week.

BENEFIT AMOUNT

You will be covered for two (2) times your annual earnings, rounded to the next higher $1,000, if not already a multiple thereof, to a maximum of $500,000.

Benefits reduce by 50% at age 70 and terminate at age 75.

In the event of your death, the Benefit Amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, while travelling on business or while you are on vacation, regardless of your history of health.

ELIGIBILITY

You will be eligible for insurance if you are a faculty member of the Policyholder, who is under the age of 65, and who regularly works no less than 18 hours per week.

Under the Family Plan, you insure your family members as follows: Your spouse (legally married or represented as your domestic partner for a period of one year or longer in the community in which you reside) who is under age 65, and your unmarried, dependent children (including step, foster, or legally adopted children) to age 19 or to age 25, if the child is a full- time student and dependent on you for support and maintenance.

Mentally or physically handicapped children will be covered beyond the maximum age shown above, provided that they are incapable of self-sustaining employment, are dependent upon you for support and maintenance.

BENEFIT AMOUNT

You may choose the benefit amount and the type of plan.

Employee Only Plan	**You may choose any amount of insurance from a minimum of $10,000 to $300,000 in units of $10,000**

Family Plan	**You may choose any amount of insurance from a minimum of $10,000 to $300,000 in units of $10,000**

You may prefer to become insured under the **Family Plan** under which your spouse and dependent children will automatically become insured. The amount of insurance which may be applied to members of your family is expressed as a percentage of the amount which you select for yourself and is based on the composition of the family at the time of loss, as follows:

Composition of Family	Spouse	Each Child
Spouse & Eligible Dependent Children	**40% of the employee's elected amount**	**15% of the employee's elected amount**
Spouse & No Eligible Dependent Children	**50% of the employee's elected amount**	**N/A**
No Spouse but Eligible Dependent Children	**N/A**	**25% of the employee's elected amount to a maximum of $100,000**

COST OF INSURANCE

The monthly premium rate for the Employee Only Plan is $0.022 per $1,000 of insurance. The Family Plan is $0.033 per $1,000 of insurance. Premium is fully paid by you through payroll deduction.

BENEFIT AND COST TABLE
(plus applicable provincial sales tax)

Benefit Amount	Employee Plan	Family Plan
$10,000	$0.22	$0.33
$50,000	$1.10	$1.65
$100,000	$2.20	$3.30
$150,000	$3.30	$4.95
$200,000	$4.40	$6.60
$250,000	$5.50	$8.25
$300,000	$6.60	$9.90

THE FOLLOWING BENEFITS ARE APPLICABLE TO BOTH THE BASIC AND VOLUNTARY INSURANCE

SCHEDULE OF LOSSES

Accidental Death & Dismemberment

If such injuries shall result in any one of the following specific losses within one year from the date of the accident, CHUBB will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet	200%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand or One Foot	66 2/3%
Loss of Entire Sight of One Eye	66 2/3%
Loss of Use of One Hand	66 2/3%
Loss of Speech or Hearing	66 2/3%
Loss of Thumb and Index Finger of Same Hand	33 1/3%
Loss of Four Fingers of Same Hand	33 1/3%
Loss of Hearing in One Ear	25%
Loss of All Toes of Same Foot	25%

"Loss" **s**hall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to "Loss of Thumb and Index finger of Same Hand" or "Loss of Four Fingers of Same Hand", the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If you suffer complete severance of a hand, foot, arm or leg as described above, then CHUBB will pay the amount specified above even if the severed limb is surgically reattached, whether successful or not.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of Use" shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to CHUBB to be permanent.

"Brain Death" means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Repatriation Benefit

When injuries covered by this plan result in a loss of life of an insured person outside 50 km from their city of permanent residence or outside of Canada and the loss of life occurs within 365 days from the date of the accident, CHUBB will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

Rehabilitation Benefit

When injuries result in a payment being made by CHUBB under any benefit excluding the Loss of Life Benefit, CHUBB will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training provided:

(a) such training is required because of such injuries and in order for the Insured employee to become qualified to engage in an occupation in which he/she would not have been engaged except for such injuries;

(b) expenses are to be incurred within two years from the date of the accident;

(c) no payment will be made for ordinary living, travelling or clothing expenses.

Family Transportation Benefit

When injuries result in an insured person being confined as an in-patient in a hospital outside 150 km their city of permanent residence or outside of Canada, and requires personal attendance of a member of their immediate family as recommended by the attending physician, in writing, CHUBB will pay for the expense incurred by the member of the family for the transportation by the most direct route by a licensed common carrier to the confined insured person , but not to exceed an amount of $15,000.

"Member of the immediate family" means the spouse, legal or common-law, parents, and grandparents, children over age 18, brother, or sister of the insured person.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by CHUBB under the Loss of Life Benefit, CHUBB will pay in addition, the expenses actually incurred, within 365 days from the date of the accident, by your spouse for a formal occupation training program for the purpose of specifically qualifying your spouse to gain active employment in an occupation for which your spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

Home Alteration and Vehicle Modification Benefit

In the event an insured person sustains an injury which results in a payment being made under this plan, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, CHUBB will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to the insured person's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by the insured person to make the vehicle accessible or driveable for the insured person.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum amount payable under both items 1 and 2 shall be the greater of $10,000 or 10% of your benefit amount to a maximum of $50,000.

Day Care Benefit

If you (the employee) suffer a loss of life in a covered accident while this policy is in force, CHUBB will pay, in addition to all other benefits payable under the policy, a "Day Care Benefit" equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of your benefit amount or a maximum of $5,000 per year, on behalf of your dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for four (4) consecutive years, but only upon receipt of satisfactory proof that your child is enrolled in a legally licensed day care centre.

"Dependent Child" means a legitimate or illegitimate child, adopted child, step-child or any child who is in a parent-child relationship with you and twelve years of age and under and dependent upon you for maintenance and support.

Special Education Benefit

If you (the employee) suffer a loss of life in a covered accident under this policy , CHUBB will pay, in addition to all other benefits payable under this policy, a "Special Education Benefit" equal to 5% of your benefit amount, (subject to a maximum of $5,000 per year), on behalf of your dependent child who, on the date of the accident, is enrolled as a full- time student in any post – secondary institution or was at the 12th grade level and subsequently enrolls as a full-time student in a post secondary institution within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of four (4) consecutive annual payments but only if your dependent child continues his/her education as a full-time student in an institution of higher learning.

If, at the time of the accident, none of the dependent children qualify, CHUBB will pay an additional benefit of $2,500 to the designated beneficiary.

Bereavement Benefit

When injuries covered by this policy result in loss of life of an Insured Person within 365 days from the date of the accident, CHUBB will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the Insured Person for up to six (6) sessions of grief counseling, by a Professional Counsellor, subject to a maximum of $1,000.

"Professional Counsellor" means the treatment or counselling by a therapist or counsellor who is licensed, registered or certified to provide such treatment.

In-Hospital Confinement Monthly Income

In the event you sustain an injury which results in a payment being made under the Schedule of Losses of this policy, excluding the Loss of Life Benefit and the Insured Person is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself, CHUBB will pay for each full month, one percent (1%) of the Insured Person's Principal Sum, subject to a maximum benefit of $2,500, or one- thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

"Hospital" as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"In-Patient" means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

Cosmetic Disfigurement Benefit

If an Insured Person suffers a third degree burn in a non-occupational accident, CHUBB will pay a percentage of the Principal Sum amount depending on the area of the body which was burned according to the following table:

Body Part	(A) Area Classification	(B) Maximum allowable % for Area Burned	(C) Maximum % of Principal Sum Payable
Face, Neck, Head	11	9%	99%
Hand & Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The maximum % of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable % for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable % for Area Burned (B) is reduced by 50%. This table only represents the maximum % of the Principal Sum payable for any one accident. If an Insured Person suffers burns in more than 1 area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Seat Belt Benefit

In the event you sustain an injury which results in a payment being made under the Schedule of Losses, your benefit amount will be increased by 10%, to a maximum of $25,000, if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.

"Seat Belt" means those belts that form a restraint system.

Identification Benefit

In the event accidental Loss of Life is sustained by the Insured Person not less than 150 km from the Insured Person's normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, CHUBB will reimburse the reasonable expenses actually incurred by such member for:

a) transportation by the most direct route to the city or town where the body is located; and
b) hotel accommodation in such city or town, subject to a maximum duration of three (3) days.

The reimbursement of such expenses incurred is subject to the accidental loss of life indemnity being subsequently payable in accordance with the terms of this policy following the identification of the body as the Insured Person. The maximum amount payable will not exceed $15,000 for all such expenses.

Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

Benefits payable under this section will be limited to only one (1) policy in the event this benefit is contained in two (2) or more policies issued to the Policyholder by CHUBB.

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert their insurance to an individual insurance policy of the Insurance Company. The individual policy will be effective either as of the date that the application is received by the Insurance Company or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as a person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of the Insurance Company. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described herein shall be covered to the extent of the benefits afforded you.

If an Insured Person's body has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which he/she was riding at the time of the accident it shall be presumed, subject to all other conditions of the policy, that he/she suffered a loss of life resulting from bodily injuries sustained in an accident covered under this plan.

Waiver of Premium

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to CHUBB on an annual basis, payment of premium will be waived until the earlier of the following occurs:

a) you return to active employment with your employer;
b) you attain age 65;
c) the master policy underwritten by CHUBB is terminated.

Once you return to active employment with your employer, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if you are unable to engage in any business or occupation and perform in any work for compensation or profit and your disability has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

Continuance of Coverage

If an Insured Employee is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Employee assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

THE FOLLOWING BENEFITS ARE APPLICABLE TO THE VOLUNTARY INSURANCE ONLY

Common Disaster Benefit (only applicable in the case of Family Coverage)

If as a result of a "common accident" you and your spouse should both lose your lives within one (1) year of such "common accident", your spouse's loss of life benefit shall be increased to equal 100% of your (employee) benefit amount.

The benefit will be payable to and equally divided among your "surviving children", or, in the case of any "surviving child" who is a minor or otherwise not competent to give valid release, CHUBB may pay such benefit to the guardian, trustee or other person deemed by CHUBB to be equitably entitled to receive such benefit. Any payment made by CHUBB in good faith pursuant to this provision shall fully discharge CHUBB to the extent of such payment.

''Common accident" means the same accident or separate accidents occurring within the same 24 hour period.

"Surviving Children" means your dependent children as defined in the definition of "eligible dependents" applicable to the policy provided such children survive both you and your spouse by at least 24 hours.

Extended Family Benefit (only applicable in the case of Family Coverage)

If an Insured Employee, who had insured his family members, suffers loss of life in a covered accident, coverage may be extended for the spouse and dependent children for a maximum of six (6) months if premiums are paid.

THE FOLLOWING PROVISIONS ARE APPLICABLE TO BOTH THE BASIC AND VOLUNTARY INSURANCE

EXCLUSIONS

The plan does not cover any loss, which is the result of:

1. intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. travel or flying in an aircraft owned or leased by the Policyholder, an Insured Person or a member of an Insured Person's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration;
4. losses occurring while an Insured Person is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by CHUBB pro-rata for any such period of full-time active duty);
5. travel or flight in any vehicle or device for aerial navigation; except to the extent such travel or flight is provided in the "Hazards Insured Against" section of the Accidental Death & Dismemberment portion of the policy.

HOW TO CLAIM

Note: In the event of a claim, notice of claim must be given to CHUBB within 30 days from the date of the accident and subsequent proof of claim must be submitted to CHUBB within 90 days from the date of the accident. A claim form can be obtained from the benefits administrator.

GENERAL PROVISIONS

Beneficiary

An employee or any spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

The 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 to be payable.

Legal Actions

No action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the policy. For residents of Alberta and British Columbia: 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. For residents of Manitoba: 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. For residents of 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. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

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).

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or to obtain information about our privacy practices, send a written request by e-mail to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

About Sun Life Financial

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

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

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

Life's brighter under the sun

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