

**The Hastings and Prince Edward
District School Board**

Elementary Teachers

**Contract Number 50632 and BSC 9026574
Effective November 24, 2005**

The Accidental Death and Dismemberment benefit is insured by American Home
Assurance Company

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General Information

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

About this booklet

The information in this employee benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life.

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

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

The contract holder, [The Hastings and Prince Edward District School Board](#), has the sole legal and financial liability for the following benefits:

- [Extended Health Care](#)
- [Emergency Travel Assistance](#)
- [Dental Care](#)

Sun Life only acts as administrator on behalf of the contract holder for the above benefits.

Eligibility

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

- you are employed by the employer or are on the employer's recall list, and

- you are designated by the employer as being eligible for coverage.
- you have completed the waiting period.

There is no waiting period for your group plan.

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

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

Who qualifies as your dependent

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

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

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

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

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

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

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

Enrolment

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

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

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

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

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

When coverage begins

Your coverage begins on the later of the following dates:

- the date you become eligible for coverage.
- the date your employer receives your enrolment information for coverage.

- the date Sun Life approves your proof of good health, if required.

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

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

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

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

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

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

Changes affecting your coverage

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

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

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

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

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

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

When coverage ends

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

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

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

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.

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

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

- 24 months after the date of your death for active employees and 12 months after the date of the Employee's death for retired employees.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

Replacement coverage

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

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

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

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim. There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. All claims must be made in writing on forms approved by Sun Life.

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

Proof of disability

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

Coordination of benefits

If you are covered for Extended Health Care or Dental Care under this plan and another plan, our benefits will be coordinated with the other plan following insurance industry standards.

These standards determine where you should send a claim first. Here are some guidelines:

- if you are claiming expenses for your spouse and the spouse is covered for those expenses under another plan, you must send the claim to your spouse's plan first.
- if you are claiming expenses for your children, and both you and your spouse have coverage under different plans, you must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

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

Medical examination

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

Recovering overpayments

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

Definitions

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

Accident

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

Basic earnings

For hourly-rated employees – Basic earnings are your hourly rate

multiplied by the average number of hours worked during the previous 12 months or from the date of employment, whichever is shorter.

For all other employees – 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 65th birthday, unless you have actually retired before then.

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

Extended Health Care (Medicare Supplement)

Plan administrator *This benefit is administered by Sun Life of Canada.*

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

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.

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

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

The benefit year is from **January 1** to **December 31**.

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

The deductible is **\$10** each benefit year for each person up to a maximum of **\$20** per family. After this deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

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

Prescription drugs We will cover the cost of drugs and supplies that are prescribed in

writing by a doctor or dentist and are obtained from a pharmacist or through Meditrust.

For the following expenses you should use your drug card:

- medication listed in the Federal or Provincial Drug Schedules which has a Drug Identification Number (DIN) and requires a prescription.
- injectable drugs and vitamins, insulin and allergy extracts with a DIN.
- preparations and compounds of which at least one ingredient is an eligible drug under this benefit.
- diabetic supplies.
- life-sustaining drugs which may not require a prescription and are identified in the Therapeutic Guide section of the current Compendium of Pharmaceuticals and Specialties.
- drugs for the treatment of infertility up to a lifetime maximum of \$2,400 for each person.
- products to help you quit smoking, which require a prescription **and over the counter drugs when prescribed in writing by a doctor**, up to a lifetime maximum of \$500 for each person.
- drugs for weight loss, which require a prescription up to lifetime maximum of \$1,800 for each person.
- oral drugs for the treatment of erectile dysfunction up to a maximum of \$1,200 for each person in a benefit year.

For the following expenses you must submit a claim to Sun Life for reimbursement:

- vaccines and compound serums that require a prescription.
- intrauterine devices (IUDs).

- colostomy supplies.
- varicose vein injections, if medically necessary.

We will cover 100% of the cost of the above medicines and supplies after you pay the deductible.

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

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatment.
- the cost of giving injections, serums and vaccines.
- medicines obtained from a doctor or dentist.
- treatments for weight loss, including drugs, proteins and food or dietary supplements, which do not require a prescription.
- muscle relaxants which do not require a prescription.
- hair growth stimulants.
- products to help you quit smoking, when not prescribed by a doctor.
- drugs for the treatment of erectile dysfunction (excluding oral drugs).

Dispensing fee Eligible expenses for the dispensing fee are limited to \$7.00 for each prescription or refill.

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

Hospital expenses in your province

We will cover 100% of the costs for out-patient services in a hospital and the difference between the cost of a ward and a semi-private hospital room in the province where you live.

We will also cover 100% of the following after you pay the deductible:

- out-patient services in a hospital.
- out-patient services in a hospital and the difference between the cost of a semi-private hospital room and private hospital room in the province where you live.
- the cost of room and board in a hospital for chronic care treatment or in a chronic wing of a hospital, up to the lesser of the difference between the cost of a semi-private hospital room or \$3 per day, up to maximum of 120 days in any 12 month period.
- the cost of room and board for nursing care in a private hospital, up to \$10 per day, up to a maximum of 120 days in any 12 month period.

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.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. 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.

**Expenses out of
your province**

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

For emergency services we will cover the cost of:

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

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

Emergency services

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

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

Services of a doctor. If an employee is confined to a hospital after the 60 day period, services are covered until the date you are discharged.

Services of private duty nurse when medically necessary including nursing supplies, up to a maximum of \$5,000 per disability. 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.

X-ray examinations and laboratory tests performed by a commercial laboratory for the diagnosis of an illness. Tests performed in a doctor's office or pharmacy are not covered.

Transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.

Transportation in a licensed air ambulance, if medically necessary, that takes you between hospitals or the cost for repatriation for admission to a hospital in your province of residence, reduced by the amount of any unused portion of the person's air ticket. The transfer must be approved in advance by your employer, unless the attending doctor certifies that the delay for such approval would endanger your life.

Casts, canes, slings, splints, trusses, braces, crutches or walkers and temporary rental of a wheelchair when acquired outside your province of residence.

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 and provided the services, prior to and after the person's return are completed within 90 days after the accident. The maximum amount payable is \$2,000 per accident.

For the following we will only cover emergency services obtained within 60 days of the date you leave the province where you live.

One-way economy airfare for transportation of the employee under medical supervision to his province of residence, plus the additional economy airfare, if required, to accommodate a stretcher, provided the employee is not holding a valid open-return air ticket. If the doctor or commercial airline stipulates in writing that the employee must be accompanied by a qualified medical attendant, charges for the attendant's (i) round-trip economy airfare, (ii) overnight hotel, and (iii) meal expenses are also considered covered expenses. The medical attendant must be registered in the jurisdiction in which the services commence.

One-way economy airfare for transportation of the employee to their province of residence if their vehicle is stolen or rendered inoperable due to an accident. The plan administrator must be provided with an official report of the theft or accident.

Meals and accommodations at a commercial establishment, up to a maximum of \$150 a day for a maximum of 10 days, for a person who, once arrived at a destination outside of their province of residence,

remains behind when the trip is delayed or interrupted due to a medical emergency or death of another member of the travelling party.

One-way economy transportation of the employee's spouse, parent, child, brother or sister from such family member's home (i) to the place where the person is hospitalized, provided the person is hospitalized for at least 7 days and the doctor verifies in writing that the situation is serious enough to necessitate the visit, or (ii) to identify the deceased person prior to the release of the body.

The return by commercial agency of an employee's vehicle, either private or rental, to the employee's province of residence or nearest appropriate vehicle rental agency when the person is unable to do so due to medical emergency or death. The maximum amount payable is \$1,000 per return of vehicle.

Up to \$5,000 for the preparation and return of the remains of a deceased person to his permanent province of residence in a coffin appropriate for transportation or up to \$2,500 for the cremation or burial of the person at the place of death

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

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

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

If contact with Worldwide Assistance cannot be made before services

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

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

***Emergency services
excluded from
coverage***

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

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

Medical services and equipment

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

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. The maximum payable is 100 eight hour shifts per person in a benefit year.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- laboratory tests performed by a commercial laboratory for the diagnosis of an illness. Tests performed in a doctor's office or pharmacy are not covered.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 90 days after the accident and be completed within 12 months after such date. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- wigs following chemotherapy, up to a lifetime maximum of 1 wig per person. Wigs do not require a doctor's order.
- equipment rented, or purchased at our request, that is for temporary therapeutic use. For expenses incurred for a

wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.

- casts, splints, trusses, braces, crutches, cervical collars, indwelling catheters, urinary kits, ostomy supplies (where a surgical stoma exists), canes and walkers.
- breast prostheses required as a result of surgery.
- surgical brassieres required as a result of surgery.
- artificial limbs and eyes.
- myoelectric appliances, up to the maximum that would be payable for a standard appliance.
- elastic support stockings, including pressure gradient hose, up to a maximum of 6 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of \$225 per pair, limited to two pairs per person in a benefit year.
- custom-made orthopaedic shoes, modifications to orthopaedic shoes and adjustment to stock item shoes and standard type footwear when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of 1 pair of shoes per person in a benefit year.
- corrective prosthetic lenses and frames following cataract surgery or when the person lacks an organic lens.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- insulin pumps.

**Paramedical
services**

We will cover **100%** of the costs after you pay the deductible for each category of paramedical specialists listed below:

- licensed psychologists, limited to \$40 per visit, up to a maximum of \$200 per person in any 12 month period.
- licensed massage therapists, when ordered by a doctor limited to \$7 per treatment, up to a maximum of 12 treatments per person in any 12 month period.
- licensed speech therapists when ordered by a doctor up to a maximum of \$200 per person in any 12 month period
- licensed physiotherapists who are not affiliated with the Ontario Health Insurance Plan. **The maximum amount payable per visit will be based on the reasonable and usual rates payable under the Ontario Health Insurance Plan in the locality where the services are provided.**
- licensed naturopaths, osteopaths, podiatrists or chiropodists, limited to \$10 per visit, up to a maximum of \$200 per person including a maximum of one x-ray examination per specialty in any 12 month period.
- nutritional counselling when ordered by a doctor, limited to \$25 for the initial visit, \$10 for a follow-up visit and \$15 for a re-examination following a break in treatment, up to a maximum of \$200 per person in any 12 month period.
- licensed chiropractors, limited to \$10 per visit, up to a maximum of \$200 per person in any 12 month period, plus \$25 for one x-ray examination when ordered by a doctor.

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

**Contact lenses,
eyeglasses or laser
eye correction
surgery**

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

We will cover 100% of these costs up to a maximum of \$300 per person every 2 benefit years starting January 1, 2005.

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

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

Coverage ends *For employees who retire prior to age 65 and who elect to continue coverage* – Coverage will end on the 31st of August following the date you turn age 65.
For all other employees – Your coverage will end on the 31st of August following the date you turn age 65 or the date you retire, whichever is earlier.

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

Payments after coverage ends

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

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

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

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

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

- services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees, extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies for which no charge would have been made in the absence of this coverage.

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.
- full term childbirth, medical complications within 9 weeks of the expected delivery date or deliberate termination of the pregnancy.
- abuse of medication, drugs or alcohol.
- intentionally self-inflicted injuries or attempted suicide (while sane or insane).

- services provided in a chronic care or psychiatric hospital, chronic unit of a hospital, confinement in a nursing home, home for the aged or health spa.
- conditions for which treatment while travelling would have been reasonably anticipated.
- therapy or psychiatric assistance given by clinics or private doctors.
- cardiac bypass surgery, or cataract surgery. However, in emergency cardiac cases, emergency medical procedures required to stabilize a person prior to return to his province of residence are considered eligible expenses.

When and how to make a claim

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

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

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

Emergency Travel Assistance

Plan administrator *This benefit is administered by Sun Life of Canada.*

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

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

If you are faced with a medical emergency when travelling outside of the province where you live, Worldwide Assistance Services, Inc. can help.

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

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

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

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

Getting help **At the time of an emergency, you or someone with you must contact Worldwide Assistance. If contact with Worldwide Assistance cannot be made before services are provided, contact**

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

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

Worldwide Assistance may arrange for:

On the spot medical assistance

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

As soon as Worldwide Assistance is notified that you have a medical emergency, its staff, or a physician designated by Worldwide 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, Worldwide Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

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

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

Transportation home or to a different medical facility

Worldwide 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, Worldwide Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Worldwide 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, Worldwide 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.

Worldwide 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 Worldwide 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

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

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

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

The plan from which you make the first claim will be responsible for

managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

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

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

Limits on Emergency Travel Assistance coverage

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

Worldwide Assistance reserves the right to suspend, curtail or limit its

services in any area, without prior notice, because of:

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

**Liability of Sun Life
or Worldwide
Assistance**

Neither Sun Life nor Worldwide 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 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.

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

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives which was current one year prior to the date the eligible expenses were incurred, regardless of where the treatment is received.

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

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

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a

separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

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

The benefit year is from [January 1](#) to [December 31](#).

Deductible

There is no deductible for this coverage.

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is [\\$3,000](#).

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$300. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

**Module A –
Preventive,
Diagnostic,
Emergency or
Palliative Services**

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

We will pay [100%](#) of the eligible expenses for these procedures.

The following procedures are covered:

- oral examinations
 - complete examinations of a new patient - limited to one during any 36 month period.
 - recall examinations of a previous patient - must be separated by an interval of at least 9 months.

- emergency examinations and/or consultation.
- specific examinations.
- consultations
 - treatment planning.
 - with patient.
 - with another Dentist.
- specific diagnostic procedures
 - bacteriologic cultures for determination of pathological agents.
 - dental caries susceptibility test.
 - biopsy, soft-hard tissues.
 - cytological examination.
 - pulp vitality tests.
- radiographs and radiographic interpretations
 - intraoral periapical films, complete series - limited to once during any 36 month period.
 - periapical films.
 - occlusal films.
 - posterior bitewing films - must be separated by an interval of at least 9 months.
 - extraoral films.
 - sinus examination.
 - sialography.
 - use of radiopaque dyes to demonstrate lesions.
 - temporomandibular joint films.
 - panoramic film - limited to one during any 36 month period.
 - cephalometric films.
 - tracing of radiographs.
 - interpretation of radiographs from another source - per unit of time.
 - tomography.
 - hand and wrist (as diagnostic aid for dental treatment).
- preventive services
 - scaling and polishing - must be separated by an interval of at least 9 months.
 - topical fluoride treatment

**Module B –
Restorative and
some Surgical
Procedures**

- oral hygiene instruction - must be separated by an interval of at least 9 months.
- caries/pain control.
- interproximal diskings of teeth.
- pit and fissure sealants.

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

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

The following procedures are covered:

- treatment of dental caries (fillings)
 - amalgam restorations of:
 - primary teeth.
 - permanent anterior and bicuspid teeth.
 - permanent molar teeth.
 - pin reinforcement.
 - stainless steel crowns.
 - silicate restorations.
 - acrylic or composite restorations.
 - occlusal equilibration - limited to 8 units of time during any 12 month period.
- surgical services - removal of teeth
 - uncomplicated removal of erupted tooth
 - single tooth.
 - each additional tooth in same surgical site.
 - surgical removal
 - removal of erupted tooth (complicated).
 - removal of impacted tooth.
 - removal of residual roots
 - soft tissue coverage.
 - bone tissue coverage.
 - anaesthesia.
 - professional visits.

**Module C –
Additional
Restorative and
Surgical Procedures**

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

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

The following procedures are covered:

- periodontal services (diagnosis and treatment of gum tissue)
 - non-surgical services - per unit of time.
 - application of displacement dressing.
 - management of acute infections and other oral lesions.
 - desensitization of tooth surface.
 - surgical services
 - gingival curettage.
 - gingivoplasty.
 - gingivectomy.
 - osseous surgery.
 - flap approach with curettage.
 - osseous grafts - single, multiple site.
 - soft tissue grafts.
 - vestibuloplasty.
 - post surgical treatment - periodontal - per unit of time.
 - adjunctive periodontal services
 - provisional splinting - intra coronal, extra coronal - unit of time.
 - periodontal scaling and root planning - per unit of time.
 - special periodontal appliances (including occlusal guards).
 - adjustments to periodontal appliances.
- endodontic services
 - pulp capping.
 - vital pulpotomy.
 - root canal therapy.
 - apexification.
 - periapical services.
 - root amputation - at one root - two roots.
 - gingival curettage.
 - alveolectomy.

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- banding of tooth to maintain sterile operating field.
 - hemisection.
 - chemical bleaching only - per unit of time.
 - intentional removal, apical filling and reimplantation.
 - emergency procedures.
 - reimplantation (excluding root canal therapy and surgery).
 - repositioning of traumatically displaced tooth.
- surgical services
 - fibrotomy.
 - surgical exposure of tooth.
 - transplantation of tooth.
 - surgical repositioning of a tooth.
 - enucleation of an unerupted tooth and follicle.
 - alveoplasty - per unit of time.
 - gingivoplasty and/or stomatoplasty.
 - osteoplasty - per unit of time.
 - surgical excisions (cysts and neoplasms).
 - surgical incision.
 - fractures.
 - frenectomy.
 - miscellaneous surgical services.
 - adjunctive general services - drugs (injections).
 - denture adjustments.

Module D – Prosthodontic Procedures

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

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

The following procedures are covered:

- denture repairs.
- denture rebasing, relining.

We will pay 60% of the eligible expenses for these procedures.

The following procedures are covered:

- complete maxillary denture (once every 5 years).
- complete mandibular denture (once every 5 years).
- complete maxillary and mandibular dentures (once every 5 years).
- removable partial dentures (once every 5 years).

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

The following procedures are covered:

- restorative services
 - gold foil restorations
 - metal inlay restorations.
 - retentive pins.
 - inlay, onlay, porcelain.
 - porcelain repair.
 - crowns.
 - post and core.
 - metal transfer coping.
 - repairs to crowns.
- prosthodontic services - fixed (once every 5 years)
 - evaluation of extensive restorative dentistry.
 - bridges.
 - retainers - inlays, onlays.
 - repairs to bridges.
 - retainers - crowns.
 - splinting.
 - retentive pins in abutments.
 - provisional coverage in extensive restorative dentistry.
 - in-office laboratory charges for items above.
 - diagnostic casts for items above.

**Module E -
Orthodontic
Procedures**

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

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

The following procedures are covered:

- orthodontic casts.
- space maintainers.
- observation and adjustment
 - observation.
 - observation and adjustment.
 - repairs.
 - alterations.
 - re-cementations.
 - separation.
- orthodontic appliances
 - removable appliances.
 - fixed – bilateral appliances.
 - fixed – unilateral appliances.
 - appliance to control harmful habits.
 - myofunctional therapy.
 - retention appliances.
- in-office laboratory charges for items above.

Coverage ends *For employees who retire prior to age 65 and who elect to continue coverage* – Coverage will end on the 31st of August following the date you turn age 65.

For all other employees – Your coverage will end on the 31st of August following the date you turn age 65 or the date you retire, whichever is earlier.

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

**Expenses Outside
Canada**

Expenses incurred for emergency dental services outside Canada are Eligible Expenses if:

- they represent the usual, customary and reasonable charges for

the procedures in the locality where they are performed, and

- charges for such procedures would be paid under this policy had the procedure been performed in the Employee's Province of residence, or if the Employee does not reside in Canada, in the Province where the Contract Holder is located.

Expenses incurred for other than emergency dental services outside Canada are Eligible Expenses up to the lesser of:

- the usual, customary and reasonable charges for the procedures in the locality where they are performed, and
- the amount that would be paid under this policy had the procedures been performed in the Employee's Province of residence, or if the Employee does not reside in Canada, in the Province where the Contract Holder is located.

Payments after coverage ends

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

What is not covered

We will not pay for services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees, extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.

- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- charges related to the temporomandibular joint (TMJ) treatment, except otherwise indicated in the list of covered expenses.

We will also not pay for dental work resulting from:

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

When and how to make a claim

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

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

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

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

Life Coverage

Insurer

This benefit is insured by Sun Life of Canada.

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

Basic Life coverage for you

Amount Your Life benefit is \$25,000 or \$100,000 as elected by you.

Reduction When you retire, your benefit amount will reduce to 50%.

Coverage ends ***For employees who retire on or after June 30th and prior to August 31st*** – You may continue coverage until August 31st otherwise coverage will end on the last day of the month in which you retire.
For all other employees – Your coverage will end on the 31st of August following the date you turn age 65 or the date you retire, whichever is earlier.

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

Optional Life coverage for you

Amount You can choose coverage in units of \$25,000. The maximum amount of coverage is \$100,000.

Coverage ends ***For employees who retire on or after June 30th and prior to August 31st*** – You may continue coverage until August 31st otherwise coverage will end on the last day of the month in which you retire.
For all other employees – Your coverage will end on the 31st of August following the date you turn age 65 or the date you retire, whichever is earlier.

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

Information.

- Who we will pay** If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.
- If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.
- Disappearance** If you disappear and the body is not found within one year, a death benefit is paid for the amount of coverage in force on the date you are presumed dead. A refund to Sun Life in the amount paid would be required if you were found alive at a later date.
- Repatriation benefit** If you die 100 kilometres or more from home, we will pay up to \$10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.
- We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.
- Spouse occupational training benefit** If you die, we will pay up to \$3,600 each benefit year up to a lifetime maximum of \$10,800, to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.
- Our approval of the training program will be based on the likelihood that it will be successful.
- Financial Planning benefit** We will pay, to the primary dependent up to \$2,000 for financial planning for expenses incurred by the primary dependent.

Identification Expenses

If you die as the result of an accident, we will pay up to \$2,000 for the reasonable and customary travelling expenses incurred by one member your immediate family from such person's home to the place of death to identify the Employee prior to the release of the body. Payment is made to the family member who incurs the expenses.

Survivor Dependent Counselling Benefit (Bereavement Counselling)

We will pay up to \$5,000 to your surviving dependents for reasonable and customary expenses incurred by such dependents for treatment by a psychologist or occupational therapist, licensed, registered or certified to provide such treatment.

Coverage during total disability

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

Sun Life must receive proof of your total disability within 18 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

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

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

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

For the purposes of your Life coverage, during the first 24 months (this period is known as the **own occupation period**), you will be considered totally disabled while you are continuously unable due to an illness to perform the essential duties of your own job at the onset of

disability, afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

Living Benefits Loan Program

If you are terminally ill with a life expectancy of 12 months or less, you may apply for a commercial loan under the Sun Life Living Benefits Loan Program. Under this program, you may receive an advance of up to 50% of your Basic Life coverage, to a maximum of \$100,000.

If you are within 6 months of a scheduled reduction of your Basic Life coverage, the advance you may receive cannot exceed 50% of the lowest reduced amount of your Basic Life coverage. This program is subject to other restrictions. Please contact your employer for details.

Converting Life coverage

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

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

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

When and how to make a claim

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

Accidental Death and Dismemberment

Insurer

This benefit is insured by American Home Assurance Company.

The Basic Accidental Death and Dismemberment plan covers you 24 hours a day, anywhere in the world, for specified accidental losses occurring on or off the job. If you suffer any of the losses listed below in the schedule of losses as the result of an accidental injury which results directly and independently of all other causes and the loss occurs within 365 days of the date of the accident, the benefits indicated below will be paid.

Who is Covered?

Class I: All active Elementary Teachers, Secondary Teachers and Senior Administration Employees of the Policyholder under the age of 70.

Class II: CUPE Employees

Amount of Coverage

Class I: \$100,000.00.

Class II: \$40,000.00

SCHEDULE OF LOSSES

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	Three-Quarters of The Principal Sum
Loss of One Leg	Three-Quarters of The Principal Sum
Loss of One Hand	Two-Thirds of The Principal Sum
Loss of One Foot	Two-Thirds of The Principal Sum

Loss of The Entire Sight of One Eye	Two-Thirds of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	One-Third of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	Two-Thirds of The Principal Sum
Loss of Hearing in One Ear	One-Sixth of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	Two-Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	Two-Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two Times The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	Two-Thirds of The Principal Sum
Loss of Use of One Arm or One Leg	Three-Quarters of The Principal Sum
Loss of Four Fingers of One Hand	One-Third of The Principal Sum
Loss of All Toes of One Foot	One-Eighth of The Principal Sum

"Loss" as above used with reference to quadriplegia, paraplegia, and hemiplegia means the complete and irreversible paralysis of such limbs; as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance through or above the first phalange; and as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing in both ears.

"Loss" as used with reference to "Loss of Use" means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss is determined to be permanent. All claims submitted under this policy for Loss of Use must be verified by agreement between a licenced practicing physician appointed by the Policyholder and a licenced practicing physician appointed by the Company, or in the event that the two physicians so appointed cannot arrive at an agreement, a third licenced practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Policyholder and the Company. This procedure may be waived by the Company at its sole discretion.

Indemnity provided under this Section for all losses sustained by any one (1) Insured Person as the result of any one (1) accident, only one of the amounts so stated in said Table, the largest shall be payable.

Exposure & Disappearance

If by reason of an accident covered by the policy an Insured Person is unavoidably exposed to the elements and, as a result of such exposure suffers a loss for which indemnity is otherwise payable hereunder, such loss will be covered under the terms of the policy.

If the body of an Insured Person has not been found within one year of disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which such person was an occupant, then it shall be deemed subject to all other terms and provisions of the policy, that such Insured Person shall have suffered loss of life within the meaning of the policy.

Beneficiary Designation

In the event of Accidental Loss of Life, benefits shall be payable as designated in writing by the Insured Person under the Policyholder's current basic group life insurance policy. In the absence of such designation, benefits shall be payable to the Estate of the Insured Person.

All other benefits shall be payable to the Insured Person.

Additional Benefits

Repatriation

If accidental death, covered by the plan, occurs more than 200 kilometres away from your permanent place of residence, the plan will reimburse the actual expenses up to \$10,000 which are incurred for the preparation and shipment of the deceased's body to the place of residence.

Rehabilitation

If you suffer an injury listed in the loss schedule, this plan will pay up to \$10,000 for special training, provided such training is required because of the covered injury and in order to qualify you for an occupation in which you would not be engaged except for the accident. All such expenses must be incurred within three years from the date of the accident and are limited to the cost of the training and materials needed for such training.

**Family
Transportation**

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 200 Km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Person's hotel accommodation in the vicinity of the hospital, and transportation to and from the hospital but not to exceed the amount of \$10,000.00.

The term "member of the immediate family" means the spouse (or common-law spouse) parents, grandparents, children age 18 and over, brother or sister of the Insured Person.

Conversion Privilege

On the date of termination of employment or during the 60 day period following termination of employment, you may change your insurance to the American Home Assurance Company's individual insurance policy. 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 policy ceases, whichever occurs later. The premium will be the same as you would ordinarily pay if you applied for an individual policy at that time. Application for an individual policy may be made at any office of the American Home Assurance Company. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Home Alteration and Vehicle Modification

If an Insured Person receives a payment under Section III - Coverage herein and was subsequently required (due to the cause for which payment under Section III - Coverage was made) to use a wheelchair to be ambulatory, then this benefit will pay, upon presentation of proof of payment:

- A. The one-time cost of alterations to the injured person's residence to make it wheel-chair accessible and habitable; and
- B. The one-time cost of modifications necessary to a motor vehicle, owned by the injured 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 on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
- ii) Vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both Items A and B combined will not exceed \$10,000.00.

Day Care Benefit

If indemnity becomes payable under the policy for accidental loss of life of an Insured Employee, the Company will pay an amount equal to the lesser of the following amounts:

- (1) The actual cost charged by such day care center per year, or
- (2) 3% of the Insured's Principal Sum, or
- (3) \$5,000.00 per year,

On behalf of any child who was an Insured's dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited day care center within 90 days following such loss.

The benefit is payable annually for a maximum of four consecutive payments but only if the dependent child continues his or her enrollment in an accredited day care center.

Continuation of Coverage

In the case of employees of the Policyholder who are (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 a period of twelve (12) months, subject to payment of premium.

If an employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Seat Belt

Benefits under the policy shall be increased by 10% as regards Insured Persons, if the covered person's injury or death results while he/she is a passenger or driver of a private passenger type automobile and his/her seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report of accident or certified by the investigating officer.

Waiver of Premium

In the event an Insured Person becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Policyholder's current group life policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier:

- (a) The date the Insured Person attains age 65.
- (b) The date of the death or recovery of the Insured Person.
- (c) The date the Master Policy is terminated.

Educational Benefit

If indemnity becomes payable for the accidental loss of life of an Insured Employee of the Holder, under the policy, the Company shall:

1. Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:

- (a) The actual annual tuition, exclusive of room and board, charged by such institution per school year.
- (b) \$5,000.00 per school year.
- (c) 5% of the Insured Employee's Principal Sum.

Such amount will be payable annually for a maximum of four consecutive annual payments, only if the dependent child continues his education.

"Dependent Child" as used herein means any unmarried child under 26 years of age who was dependent upon the Insured Employee for at least 50% of his maintenance and support.

"Institution of higher learning" as used herein includes, but is not limited to, any University, Private College, or Trade School.

- 2. Pay to or on behalf of the surviving spouse the actual cost incurred within 30 months from the date of death of the Insured Employee as payment for any professional or trades training program in which such spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of \$10,000.00.

**In-Hospital
Indemnity Benefit**

If an Insured suffers a loss under the Table of Losses as a result of a covered accident and requires that an Insured be confined to a hospital for more than five (5) consecutive days, We will pay:

- (a) a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
- (b) for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

This benefit is limited to:

- (a) a monthly amount not to exceed \$1,000.00; and
- (b) a total of twelve (12) months for any covered accident.

Successive periods of hospital confinement for loss from the same covered accident separated by a period of less than three (3) months will be considered as one (1) period of hospital confinement.

The term "**Hospital**" is defined as an establishment which meets all of the following requirements:

- (1) holds a license as a hospital (if licensing is required in the province);
- (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- (3) provides 24-hour a day nursing service by registered or graduate nurses;
- (4) has a staff of one or more licensed physicians available at all times;
- (5) provides organized facilities for diagnosis, and major medical surgical facilities; and
- (6) is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Exclusions

The accident insurance plan does not cover any loss resulting from:

- Suicide or self-inflicted injuries;
- Full-time service in the Armed Forces;
- Declared or undeclared war or any act thereof;
- Injuries received during aircraft travel except for the purposes of transportation where the member is travelling as a passenger.

