

your **group**
benefits



OAKVILLE

The Corporation of the Town of Oakville

Active firefighters

**Contract Number 56261 and AB102168
Effective October 1, 2018**

Published Date March 22, 2019

The Basic Accidental Death and Dismemberment benefit is insured by ACE INA Insurance

IMPORTANT INFORMATION

Benefit coverage based on Collective Agreement for period January 1, 2018 to December 31, 2022.

Name:

Identification Number:

Personal Identification Number (PIN) or password _____. This is used when telephoning to inquire about your claims history. Please note this is unique to you and should be kept confidential.

Sun Life Medical and Dental inquiries:

Toronto (416) 753-4300

TOLL-FREE 1-800-361-6212

Fax Number (416) 490-0224

Sun Life Financial Plan Member Services website at www.mysunlife.ca

Address Sun Life Assurance
Company of Canada
Health Claims Office
P O Box 4023 Station A
Toronto ON M5W 2P7

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General Information

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or 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 Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

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

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

The contract holder, The Corporation of the Town of Oakville, self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care

This means that The Corporation of the Town of Oakville plays a role similar to that of an insurance company for its employees. The Corporation of the Town of Oakville has the sole legal and financial liability for the benefits listed above and funds the claims from its net income, retained earnings or other financial resources. Sun Life provides administrative services only (ASO) such as claims processing. All other benefits are insured by Sun Life.

Eligibility

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

- you are a permanent full-time employee, including if you are satisfying the probationary period as a full-time permanent employee.
- you are actively working for your employer at least 30 hours a week.
- you have completed the waiting period.

The waiting period for your group plan ends on the last day of the month in which you have completed 3 months of continuous employment.

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

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

Your children and your spouse's children (other than foster children), if

they are not married or in any other formal union recognized by law, are under age 21 and work less than 30 hours a week, unless they are a full-time student, are eligible dependents.

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.

When coverage begins

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

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

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

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

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

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

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

Accessing your records

For insured benefits, you may obtain copies of the following documents:

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

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

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

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

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

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

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

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

- the date your coverage ends.

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

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

Surviving dependent coverage

If you die while covered by this plan, coverage for your dependents will continue until the earlier of the dates below. The continuation of coverage includes Extended Health Care and Dental Care, other than orthodontic procedures.

- for your spouse's coverage:
 - the date your spouse becomes eligible for coverage under another group plan.
 - the date your spouse reaches age 65.
 - the date the benefit provision under which your spouse is covered terminates.

Coverage for your spouse will continue, without premium payment for the first 6 months after the date of your death (the first 12 months if you die in the line of duty). After this time, your spouse may elect to continue coverage with premium payment

- for your dependent child's coverage:
 - the date the dependent child becomes eligible for coverage under another group plan.
 - the date the dependent child reaches age 21.
 - the date the benefit provision under which the dependent child is covered terminates.

However, if you die in the line of duty, the coverage in effect at the date of your death will continue for your spouse and dependent

children (under age 21) until the date you would have reached age 65 if you were still alive.

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions 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 total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Coordination of benefits

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

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

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

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

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

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

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order

applies:

- the plan where the person is covered as an active full-time employee.
- the plan where the person is covered as an active part-time employee.
- the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Your retirement date is your 60th birthday or the date that you retire, whichever is earlier.

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

Extended Health Care (Medicare Supplement)

Plan administrator	<i>This benefit is administered by Sun Life Assurance Company of Canada.</i>
General description of the coverage	<p>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.</p> <p>In this section, <i>you</i> means the employee and all dependents covered for Extended Health Care benefits.</p> <p>Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs (see <i>Prior authorization program</i> for details).</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.</p> <p>The benefit year is from January 1 to December 31.</p>
Deductible	<p>The deductible is the portion of claims that you are responsible for paying.</p> <p>The deductible for prescription drugs is the portion of any dispensing fee over \$16 for each prescription or refill.</p>

For other expenses, there is a deductible of \$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.

Prescription drugs

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*.

After you pay the deductible, we will cover 100% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs, including over-the-counter drugs.
- injectable drugs and vitamins.
- oral vitamins and mineral supplements.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$500 for each person.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.
- muscle relaxants. You will be required to provide a pharmacy receipt including the product name and DIN number, the cost, the patient's name and the date the medication was dispensed.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.

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

- infant formulas (milk and milk substitutes), proteins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug evaluation The following drugs will be evaluated and must be approved by us to be eligible for coverage:

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

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- comparative analysis of the drug cost and its clinical effectiveness.
 - recommendations by health technology assessment organizations and provinces.
 - availability of other drugs treating the same or similar conditions(s).
 - plan sustainability.

***Prior authorization
program***

The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.

In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

- our website at www.mysunlife.ca/priorauthorization
- our Customer Care centre by calling toll-free 1-800-361-6212

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

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

**Hospital expenses in
your province**

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

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

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

- it follows at least 3 consecutive days of in-patient hospitalization,
- it begins within 14 days of release from the hospital, and
- it is primarily for rehabilitation.

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

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

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest

home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Expenses out of your province

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

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

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

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

Emergency services

We will pay 100% of the cost of covered emergency services without a deductible.

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

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global 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 Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global 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 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. We will pay 100% of the costs of referred services without a deductible. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

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

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

Emergency services out of your province Expenses incurred for emergency services outside the province where you live are subject to a maximum of \$1,000,000 per person per occurrence or, if lower, any other applicable lifetime maximum.

Referred services out of your province Expenses incurred for referred services outside the province where you live are subject to a lifetime maximum of \$50,000 per person or, if lower, any other applicable lifetime maximum.

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

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you

live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of \$25,000 per person during any 3 consecutive benefit years.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- laboratory tests performed by a commercial laboratory for the diagnosis of an illness. Tests performed in a doctor's office or pharmacy are not covered.
- prostate specific antigen (PSA) tests performed by a commercial laboratory.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 6 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- equipment rented, or purchased at our request, that is for temporary therapeutic use.
- casts, splints, trusses, braces or crutches.
- custom made back supports.

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- artificial limbs and eyes, excluding myoelectric appliances.
 - elastic support stockings, including pressure gradient hose, up to a maximum of 1 pair per person in a benefit year.
 - wigs following chemotherapy or radiation therapy, when ordered by a doctor, up to a maximum of \$500 per person in a benefit year.
 - 1 pair of custom-made orthopaedic shoes or custom-made orthotic inserts for shoes every benefit year, when prescribed by a doctor, podiatrist or chiropodist.
 - hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$2,500, including batteries and ear moulds when necessary as part of the hearing aid device, per person every 36 months. Repairs are included in this maximum.
 - radiotherapy or coagulotherapy.
 - oxygen, plasma and blood transfusions.
 - glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of \$350 per person.

Paramedical services

For each category of paramedical specialists listed below we will cover:

- 100% of the costs, after you pay the deductible, for licensed speech therapists, when ordered by a doctor, up to a maximum of 50 visits per person each benefit year.
- 100% of the costs, after you pay the deductible, for licensed naturopaths up to a maximum of \$500 per person each benefit year.
- 100% of the costs, after you pay the deductible, up to a maximum of \$500 per person each benefit year for the services of licensed osteopaths or osteopathic practitioners in addition to a maximum of one x-ray examination per person each benefit year.

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- 100% of the costs, after you pay the deductible, for licensed chiropractors to a maximum of \$800 per person each benefit year. In addition, a maximum of \$100 will be payable for x-ray examinations per person each benefit year.
 - 100% of the costs, after you pay the deductible, for licensed physiotherapists or occupational therapists.
 - 100% of the costs, after you pay the deductible, for licensed athletic therapists up to a maximum of \$800 in a benefit year for the employee and spouse only.
 - 100% of the costs, after you pay the deductible, for licensed massage therapists, when ordered by a doctor up to a maximum of \$1,200 (*\$1,300 effective January 1, 2020, \$1,400 effective January 1, 2021, \$1,500 effective January 1, 2022*) in a benefit year for the employee and spouse only.
 - 100% of the costs, after you pay the deductible, for licensed psychologist, licensed psychotherapists or psychotherapists who are active members of a provincial association approved by Sun Life, when ordered by a doctor, up to a maximum of \$3,000 each benefit year per person.

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.

Vision care

We will cover the costs for:

- contact lenses or eyeglasses, including replacement lenses and/or frames, tinting of lenses, and prescription sunglasses, prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician.
- laser eye correction surgery performed by an ophthalmologist.

We will cover 100% of these costs, without a deductible, up to a maximum of \$650 in any 24 month period per person.

We will also cover the cost of contact lenses for special conditions such as severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), aphakia or when acuity in the better eye cannot be improved to at least 20/40 with glasses, up to a lifetime maximum of \$525 for each person.

We will also cover 100% of the costs for services of an ophthalmologist or licensed optometrist, up to a maximum of \$80 in any 24 month period per person.

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

When coverage ends Extended Health Care coverage will end on the last day of the month in which the employee retires or reaches age 60, 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, a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

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

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

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government*

programs.

- services or supplies to the extent that their costs exceed the reasonable and customary rates in the locality where the services or supplies are provided.
- stimulator and supplies.
- abdominal, spinal, wrist and obus back supports.
- tens machine
- 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.

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.

We will also not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.

**Integration with
government
programs**

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

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

- whether you have made an application to the government program,

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

When and how to make a claim

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

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

- the end of the benefit year during which you incur the expenses, or

the end of your Extended Health Care coverage.

Emergency Travel Assistance

Plan Administrator	<i>This benefit is administered by Sun Life Assurance Company of Canada.</i>
General description of the coverage	<p>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.</p> <p>In this section, <i>you</i> means the employee and all dependents covered for Emergency Travel Assistance benefits.</p> <p>If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (<i>Allianz Global Assistance</i>) can help.</p> <p><i>Emergency</i> means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.</p> <p>This benefit, called Medi-Passport, supplements the emergency portion of your Extended Health Care coverage. It only covers 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.</p> <p>The Medi-Passport coverage is subject to any maximum applicable to the emergency portion of the Extended Health Care benefit.</p> <p>We recommend that you bring your Travel card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.</p>
Getting help	<p>At the time of an emergency, you or someone with you must contact Allianz Global Assistance. If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are</p>

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

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

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.

Based on medical factors, a physician designated by Allianz Global Assistance 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; 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, Allianz Global 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

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

Vehicle return

Allianz Global 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, Allianz Global 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

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 Allianz Global 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 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. 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 Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure.

Allianz Global 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 Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

Allianz Global Assistance will not provide services in the province where you live, or during any trip taken for the purpose of seeking medical attention.

**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	<i>This benefit is administered by Sun Life Assurance Company of Canada.</i>
General description of the coverage	<p>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.</p> <p>In this section, <i>you</i> means the employee and all dependents covered for Dental Care benefits.</p> <p>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.</p> <p>For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time the treatment is received.</p> <p>Services provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality are limited to the amount payable under the Fee Guide for general practitioners.</p> <p>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.</p> <p>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.</p>

The benefit year is from January 1 to December 31.

Deductible	There is no deductible for this coverage.
Benefit year maximum	For Major dental procedures, we will not pay more than: <ul style="list-style-type: none"> ■ \$2,000 per person for each benefit year for procedures related to dentures and ■ \$3,500 per person for each benefit year for all other Major dental procedures.
Lifetime maximum	The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is \$4,000.
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 \$200. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.
Preventive dental procedures	Your dental benefits include 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.
<i>Oral examinations</i>	1 complete examination every 36 months. 1 recall examination every 9 months. Emergency or specific examinations.
<i>X-rays</i>	1 complete series of x-rays or 1 panorex every 36 months. 1 set of bitewing x-rays every 9 months. X-rays to diagnose a symptom or examine progress of a particular

course of treatment.

Other services Required consultations with another dentist.

Polishing (cleaning of teeth) once every 9 months.

Topical fluoride treatment once every 9 months, for children under the age of 18 only.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once per lifetime.

Basic dental procedures

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

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

Fillings Amalgam, composite, acrylic, or equivalent.

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

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

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

Periodontics Treatment of disease of the gum and other supporting tissue, excluding temporomandibular joint (TMJ) treatment.

Occlusal equilibration, 8 units every 12 months.

Scaling and root planing

Tartar removal. Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

You are covered for up to 8 units of 15 minutes of tartar removal per person in a benefit year.

Oral surgery

Surgery and related anaesthesia, including transplantation of erupted teeth, other than: removal of impacted teeth (*Preventive dental procedures*), implants, transplants of unerupted teeth and repositioning of the jaw.

Major dental procedures

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

Of the eligible expenses, we will pay:

- 50% for procedures related to dentures, and
- 100% for all other procedures.

Major restorations

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

Repair

Repair of bridges or dentures.

Rebase or reline

Rebase or reline of an existing partial or complete denture.

Prosthodontics

Construction and insertion of bridges (including porcelain bridges on molars) or standard dentures. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

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

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

Diagnostic casts.

Orthodontic procedures

Your dental benefits include procedures used to treat misaligned or crooked teeth. Only persons age 6 or over are covered for these procedures.

We will pay 50% of the eligible expenses 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 Dental Care coverage will end on the last day of the month in which the employee retires or reaches age 60, whichever is earlier.

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

Payments after coverage ends

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

What is not covered

We will not pay for services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees and extra billing if the legislation allows private plans to cover the user

fees and extra billing.

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

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.
- 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).

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.

We will not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Act or similar legislation.

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

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

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 to you if you are totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

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

For your Long-Term Disability coverage,

- during the elimination period and the following 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 do the essential duties of your own occupation, and
- 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.

If you have 35 or more years of employment with your employer, you will be considered totally disabled while you are prevented by illness from performing the essential duties of your own occupation.

If you must hold a government permit or licence to perform your own occupation and your permit or licence is withdrawn or not renewed solely for medical reasons, we will consider you totally disabled for up to 12 months after the end of the elimination period. You cannot be working other than in a Sun Life approved partial disability or rehabilitation program.

Benefits are paid at the end of each month and are based on your coverage on the date you became totally disabled.

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

Proof of good health Proof of good health is required for coverage in excess of \$7,500, and any increase in that coverage of 25% or more or \$500, whichever is greater. Coverage will not take effect before Sun Life approves the proof of good health.

When disability payments begin Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 105 days or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 105 days and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay Here is how we calculate your Long-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take 75% of your monthly basic earnings up to a maximum of \$12,000.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.

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- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
 - under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
 - under a group plan, including any coverage resulting from your membership in an association of any kind.
 - under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
 - under the Québec Parental Insurance Plan.

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

If this amount plus the above sources of income and all the additional sources of income listed below exceeds 85% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 85% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

- under any Workers' Compensation Act or similar law for another disability, excluding any automatic cost-of-living increases that occur after benefits begin.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above 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 that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

We have the right to adjust your benefit payments when necessary.

**Maternity / parental
leave of absence**

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 105 days, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

**Partial disability
program**

You may be required to participate in a partial disability program approved by Sun Life in writing.

After you are eligible for Long-Term Disability payments, you may be considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

During your partial disability program, you can receive a salary from your employer for the hours worked. However, your Long-Term Disability payments will be reduced by the percentage of your normal work week that you are now working for your employer.

During your partial disability program your total income from all sources cannot exceed 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable). If this is the case, your Long-Term Disability payments will be further reduced by the excess.

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

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

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

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long-Term Disability payments plus income from other sources. However, if during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long-Term Disability payments will be reduced by the excess.

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

interruption of the elimination period.

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and all of the following conditions are met:

- the initial period of total disability lasts for at least 30 days without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the elimination period.

If the Long-Term Disability benefit terminates, any balance of the elimination period must subsequently be completed by uninterrupted total disability.

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 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. You must be covered when total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability.

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.

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

We have the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

Your responsibilities During your total disability, you must make reasonable efforts to:

- 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.
- obtain training in order 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 obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

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 last day of the month in which you reach age 60.
- the last day of the month in which you die.

When coverage ends Long-Term Disability coverage will end on the last day of the month following your retirement date as defined in this booklet less the

elimination period of 105 days. Coverage may also end on an earlier date, as specified in *General Information*.

What is not covered We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- 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 except as stated under *Maternity / parental leave of absence* or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if 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 by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- you became totally disabled more than 12 months after your coverage began.

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.

**When and how to
make a claim**

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.

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

We must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins.
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give us as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, we must receive these forms no later than 90 days after the end of the elimination period.

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 total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

Life Coverage

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada</i>
General description of the coverage	Your Life coverage provides a benefit for your beneficiary if you die while covered.
Life coverage for you	<p><i>Amount</i> Your Life benefit is 2 times your annual basic earnings, rounded to the next higher \$1,000. The maximum amount of coverage is \$300,000.</p> <p>Your coverage will end on the last day of the month in which you retire or reach age 60, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i>.</p>
Who we will pay	<p>If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.</p> <p>If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.</p> <p>A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.</p>

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.

Basic Accidental Death and Dismemberment

Insurer

*This benefit is insured by ACE INA Insurance,
policy number: AB10216801*

COVERAGE

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

ELIGIBILITY

All active, permanent, full-time Firefighters of The Corporation of the Town of Oakville who have completed 3 months of continuous service, under age 60.

BENEFIT AMOUNT

Two (2) times *annual earnings to a maximum of \$300,000.

*The term “annual earnings” as used herein shall mean an Insured Person’s basic annual earnings, excluding overtime, bonus or commission.

Benefit terminates on the last day of the month immediately following the Insured Person’s 60th birthday.

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.

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, ACE INA Life Insurance 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 or One Foot	66 2/3%
Loss of Speech or Hearing in Both Ears	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	12 1/2%

"Loss" shall 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 the insured suffers complete severance of a hand, foot, arm or leg as described above, then ACE INA Life Insurance will pay the amount specified in the Schedule of Losses 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, or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to ACE INA Life Insurance 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 outside 100 km from your city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, ACE INA Life Insurance 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 ACE INA Life Insurance under any benefit excluding the Loss of Life benefit, ACE INA Life Insurance 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 you to become qualified to engage in an occupation in which you would not have been engaged except for such injuries;
- (b) expenses are to be incurred within three 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 your confinement as an in-patient in a hospital outside 150 km from your city of permanent residence or outside Canada and requires personal attendance of a member of your immediate family as recommended by the attending physician, in writing, ACE INA Life Insurance will pay for the expense incurred by your family member, for the transportation by the most direct route by a licensed common carrier to you, while confined, but not to exceed an amount of \$15,000.

“Member of your immediate family” means your spouse, (legal or common-law), parents, grandparents, children, over age 18, brother or sister.

Spousal Occupational Training Benefit

When injuries to you result in a payment being made by ACE INA Life Insurance under the Loss of Life benefit, ACE INA Life Insurance will pay in addition, the expenses actually incurred, within 3 years 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 you sustain an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, ACE INA Life Insurance 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 your principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by you to make the vehicle accessible or driveable for you.

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 payable under both Items 1 and 2 shall be the expense actually incurred up to the greater of \$15,000 or 10% of the Insured Person's Principal Sum amount to a maximum of \$50,000.

Day Care Benefit

If you suffer a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance 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 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 either a legitimate or illegitimate child, adopted child, step-child or any child who is in a parent-child relationship with you and who is twelve (12) years of age and under and dependent upon you for maintenance and support.

Continuance of Coverage

If you 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 12 months, subject to the payment of premiums.

If you assume 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.

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% 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.

Special Education Benefit

If you suffer a loss of life in a covered accident while the policy is in force, ACE INA Life Insurance will pay, in addition to all other benefits payable under this policy, a “Special Education Benefit” up to 5% of your Benefit amount, (subject to a maximum of \$5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident.

The “special education benefit” is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

Conversion Privilege

On the date of termination of employment or during the 31-day period following termination of employment, you may convert your insurance to an individual insurance policy of ACE INA Life Insurance. The individual policy will be effective either as of the date that the application is received by ACE INA Life Insurance 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 ACE INA Life Insurance. The amount of insurance benefit converted shall not exceed that amount issued during employment.

Waiver of Premium

If you are under age 60 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to ACE INA Life Insurance 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 60;
- (c) the master policy underwritten by ACE INA Life Insurance 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 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.

Identification Benefit

In the event accidental Loss of Life is sustained by you not less than one hundred and fifty (150) kilometers from your 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, ACE INA Life Insurance 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 ACE INA Life Insurance.

In-Hospital Indemnity

In the event you sustain an injury which results in a payment being made under the Schedule of Losses excluding the Loss of Life Benefit and you are hospital confined as an in-patient and are under the care of a legally qualified and registered physician or surgeon other than himself, ACE INA Life Insurance will pay for each full month, one percent (1%) of your 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.

Bereavement Benefit

When injuries covered by this policy result in loss of life within 365 days from the date of the accident, ACE INA Life Insurance 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 a therapist or counsellor who is licensed, registered or certified to provide such treatment.

Cosmetic Disfigurement Benefit

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 percent of Principal Sum Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable percent for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%.

This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of \$25,000.

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. war or any act thereof;
3. flying in an aircraft owned or leased by your employer, yourself or a member of your household, or aircraft being used for any test or experimental purpose, firefighting, powerline inspection, pipeline inspection, aerial photography or exploration;
4. full-time, active duty in the armed forces.
5. flying as pilot or crew member in any aircraft or device for aerial navigation.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded you.

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

How to Claim

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

This brochure has been prepared in connection with a group plan underwritten by ACE INA Life Insurance. For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

Underwritten by: **ACE INA Life Insurance**

Effective Date: **February 8, 2008**

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit www.sunlife.ca/privacy.

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).

