your group benefits

Schenker of Canada Limited

(Flex Benefit Employees)

Group Policy No 87353
Effective January 1, 2023
Issued October 26, 2022

Schenker of Canada Limited

Flex Benefit Employees

Life and Accidental Death and Dismemberment for Employees, Dependant Life,
Optional Life and Accidental Death and Dismemberment for Employees,
Optional Life and Accidental Death and Dismemberment for Spouse,
Long Term Disability, Extended Health and Dental Insurance

Underwritten by: Sun Life Assurance Company of Canada

Group Policy No. 87353

Short Term Disability Insurance Provision

Underwritten by: Schenker of Canada Ltd.

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Your Group Insurance Booklet

Keep in a safe place

This booklet is a valuable source of information for you and your family. It provides the information you need about the group benefits available through your employer's group plan with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies. Please keep it in a safe place. We also recommend that you familiarize yourself with this information and refer to it when making a claim for group benefits.

Your Plan Administrator is there to help

Your plan administrator can:

- help you enrol in the plan
- provide you with the forms you need to claim group benefits
- answer any questions you may have

Benefits and claims information at your fingertips

For more information about your group benefits or claims, please call Sun Life's Customer Care Centre toll-free number at 1-800-361-6212.

We're on the Internet!

Learn more by surfing Sun Life's website. There's information about group benefits, and about Sun Life's products and services... and a whole lot more! Check us out!

Our address is:

www.sunlife.ca

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 policy.

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 Sun Life Financial Customer Care centre by calling toll-free at 1-800-361-6212.

The statements in this booklet are only a summary of some of the provisions in the master policy. If you need further details on the provisions which apply to your group benefits you must refer to the master policy (available from your plan administrator).

Summary of Insurance

Policy Number *87353*

Life Insurance and Accidental Death and Dismemberment Insurance for Employees

Class of Members	Benefit Formula	Maximum Benefit
Flex Benefit Employees	2x annual earnings	$750,000

Termination of Insurance: 70th birthday or retirement, if earlier

Dependant Life Insurance

Spouse: $10,000

Each Child: $5,000

Termination of Insurance: member's 70th birthday or retirement, if earlier

Optional Life and Accidental Death and Dismemberment Insurance for Employees

Class of Members	Benefit Formula	Maximum Benefit
Flex Benefit Employees	units of $10,000	$500,000

Termination of Insurance: 65th birthday

Optional Life and Accidental Death and Dismemberment for Spouse

Class of Members	Benefit Formula	Maximum Benefit
Flex Benefit Employees	units of $10,000	$500,000

Termination of Insurance: the earlier of the member's 65th birthday, member's retirement, or the spouse's 65th birthday

Short Term Disability Insurance

Short Term Disability Insurance Provision is underwritten by Schenker of Canada Ltd.

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit	
		Non-Evidence Maximum	Evidence Maximum
Flex Benefit Employees	70% of monthly earnings	$12,000	$15,000

Monthly Disability Benefit

All references to income below and in the Long Term Disability Insurance Provision are to the gross amounts before any deductions.

Your monthly disability benefit is the lesser of 1. and 2. below:

1. the benefit formula applied to your gross monthly earnings, limited to the maximum monthly benefit, less any disability and retirement income you receive from:
   a. the Canada/Quebec Pension Plan or a similar pension plan, excluding benefits for dependent children.
   b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
   c. an automobile insurance policy.
   d. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.
2. 85% of your gross monthly earnings in force on the date you became totally disabled if the benefit is subject to income tax, or your net monthly earnings if the benefit is not subject to income tax, less any disability and retirement income you receive from:
   a. the Canada/Quebec Pension Plan or a similar pension plan, excluding benefits for dependent children.
   b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
   c. an automobile insurance policy.
   d. another group insurance policy.
   e. a retirement income plan providing income that becomes payable after you are no longer actively at work.
   f. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.

If your employer pays any portion of the Long Term Disability premium, your monthly disability benefit is subject to income tax.

If you pay 100% of the Long Term Disability premium, your monthly disability benefit is not subject to income tax.

Total Disability and Totally Disabled: mean that,

- during the qualifying period and the 24 month period immediately following it, you have a medical impairment due to injury or disease which prevents you from performing, in any setting, the essential duties of the occupation in which you participated just before the total disability started, and
- after the 24 month period, you are unable, because of the medical impairment, to perform, in any setting, the essential duties of any occupation for which you have at least the minimum qualifications.

The medical impairment must be supported by objective medical evidence.

The availability of work for you does not affect the determination of totally disabled or total disability.

Qualifying Period: 182 days

Benefit Period: to 65th birthday

Termination of Insurance: 65th birthday or retirement, if earlier

Extended Health Insurance (Option 1)

Any leftover plan credit will be put into a healthcare spending account.
Carry over is only for one year.

Part	Benefit	Deductible per family unit	Reimbursement
E	Out-of-Province Emergency and Travel Assistance	none	100%

Termination of Insurance: member's retirement

Extended Health Insurance (Option 2)

Part	Benefit	Deductible per family unit	Reimbursement
A	Drug: Pay Direct	*	75%**
B	Vision: $275***	none	100%
C	Hospital: ward to semi-private	none	100%****
D	Supp. Health Care	none	75%
E	Out-of-Province Emergency and Travel Assistance	none	100%

*The deductible is equal to the amount charged for the dispensing fee.

**When $3,750 of out-of-pocket expenses have been incurred by you and each insured dependant under Part A in a calendar year, eligible expenses for the remainder of the calendar year will be reimbursed at 100%.

***Maximum for eyeglasses/contact lenses every 24 month period for you and for each insured dependant.

****Maximum reimbursement for convalescent hospital is 75%.

Other maximums are listed under the appropriate Provision page.

Termination of Insurance: member's retirement

Drug coverage for Québec residents

For all members under age 65 and members age 65 and over who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, your out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Termination of Insurance: member's retirement

Extended Health Insurance (Option 3)

Part	Benefit	Deductible per family unit	Reimbursement
A	Drug: Pay Direct	*	90%**
B	Vision: $375***	none	100%
C	Hospital: ward to private	none	100%****
D	Supp. Health Care	none	90%
E	Out-of-Province Emergency and Travel Assistance	none	100%

*The deductible is equal to the amount charged for the dispensing fee.

**When $1,500 of out-of-pocket expenses have been incurred by you and each insured dependant under Part A in a calendar year, eligible expenses for the remainder of the calendar year will be reimbursed at 100%.

***Maximum for eyeglasses/contact lenses every 24 month period for you and for each insured dependant.

****Maximum reimbursement for convalescent hospital is 90%.

Other maximums are listed under the appropriate Provision page.

Termination of Insurance: member's retirement

Drug coverage for Québec residents

For all members under age 65 and members age 65 and over who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, your out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Termination of Insurance: member's retirement

Dental Insurance (Option 1)

No coverage is available under Option 1: The plan credit will be put into a healthcare spending account.

Dental Insurance (Option 2)

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/ Preventive	none	75%	$1,500*
B	Restorative	none	75%	*
D	Periodontic	none	50%	*
E	Denture	none	50%	*
F	Bridge	none	50%	*
G	Crown	none	50%	*
H	Endodontic	none	50%	*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for you and for each insured dependant.

Late Entrant Maximum: If your eligible dependant becomes insured more than 31 days after the date you became eligible for the Dental Insurance Provision, the maximum amount payable for the combined eligible expenses of all parts incurred during the first 12 months of insurance will be limited to $250 for each insured dependant.

Termination of Insurance: member's retirement

Dental Fee Guide: The applicable fee guide is the one in force for general practitioners on the day when the expense is incurred. For expenses incurred within Canada, the province where the expense is incurred determines the applicable fee guide, or, for expenses incurred outside Canada, the member’s province of residence.

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

Dental Insurance (Option 3)

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/ Preventive	none	100%	$2,000*
B	Restorative	none	100%	*
C	Orthodontic	none	50%	$1,500**
D	Periodontic	none	70%	*
E	Denture	none	60%	*
F	Bridge	none	60%	*
G	Crown	none	60%	*
H	Endodontic	none	70%	*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for you and for each insured dependant.

**The maximum lifetime amount payable applies to the eligible expenses incurred under Part C for you and for each insured dependant.

Late Entrant Maximum: If your eligible dependant becomes insured more than 31 days after the date you became eligible for the Dental Insurance Provision, the maximum amount payable for the combined eligible expenses of all parts incurred during the first 12 months of insurance will be limited to $250 for each insured dependant.

Termination of Insurance: member's retirement

Dental Fee Guide: The applicable fee guide is the one in force for general practitioners on the day when the expense is incurred. For expenses incurred within Canada, the province where the expense is incurred determines the applicable fee guide, or, for expenses incurred outside Canada, the member’s province of residence.

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

Health Spending Account (Non-Insured Benefit)

The calendar year is from January 1 to December 31.

Plan credits: Remaining Flex credits on the commencement of each calendar year.

If your coverage starts after the commencement of the calendar year, your plan credits are adjusted by the employer for that calendar year. If you need additional information, please contact your employer.

Termination of Insurance: member's retirement

General Information

Eligibility

You are eligible, and continue to be eligible, to be a member while you meet all of the following conditions:

1. You are actively working for Schenker of Canada Limited.
2. You regularly work for Schenker of Canada Limited at least 20 hours each week.
3. You have been continuously employed by Schenker of Canada Limited at least as long as the waiting period.
4. You are a resident of Canada.

Participation is compulsory with the exception of Optional Life and Optional Accidental Death and Dismemberment Insurance.

Waiting Period – The first of the month following 3 full months of continuous employment

You are eligible, and continue to be eligible, for dependant insurance while you meet all of the following conditions:

1. You are a member.
2. You have at least one dependant.
3. Your dependants are residents of Canada.

Definitions

Dependant

means your spouse or a dependent child of you or your spouse. If Sun Life does not approve evidence of insurability required for a dependant, he will not be an insured dependant.

Dependent Child

means a natural, adopted or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on you for maintenance and support and who is

1. under 22 years of age,
2. under 25 years of age (26 years of age for the Extended Health Benefit for Québec residents only) and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

He, his and him

refer to both genders.

Spouse

means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship.

Enrolment

To enrol for Optional Life Insurance submit a completed enrolment form and evidence of insurability to Sun Life. To enrol for Optional Dependant Life Insurance you must submit a completed enrolment form and evidence of insurability for your spouse to Sun Life.

To enrol for all other insurance submit a completed enrolment form. If you have a dependant, request dependant insurance when you enrol.

If you request dependant insurance more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life.

If you have no dependant when you enrol and later acquire one, request dependant insurance, (e.g. birth of first child, marriage).

If your new dependant is a common-law spouse, see your Plan Administrator to find out how to enrol for dependant insurance.

For late entrants, evidence of insurability submitted to Sun Life is at your expense.

Effective Date

Your Optional Life Insurance is effective on the later of the date that you become eligible or the date that Sun Life approves the evidence of insurability.

You become eligible for all other insurance on the first of the month coinciding with or following the date you become eligible.

Your dependant insurance is effective on the latest of

1. the date that you become eligible for dependant insurance,
2. the date that you request dependant insurance, or
3. the date that Sun Life determines the insurability of all of your dependants, and approves at least one dependant.

If you are absent from work on the date your insurance or your dependant insurance would be effective, then that insurance will not be effective until the date you return to active work.

Changes in Insurance

If you request an increase in the amount of Optional Life Insurance, you must submit evidence of insurability to Sun Life. If you request an increase in the amount of Optional Dependant Life Insurance, you must submit evidence of insurability for your dependants to Sun Life. The increase in the amount of insurance will be effective on the date that Sun Life approves the evidence of insurability.

An increase in your benefits, the amount of your insurance or the amount of your dependant insurance due to a change in your group benefit plan's design or a change in your classification becomes effective on the date of the change, unless you are not actively working on that day.

If Sun Life doesn't approve an increase in the amount of your insurance or the amount of your dependant insurance, any future increase in the maximum benefit amount will not be effective unless evidence of insurability is approved. An increase in the maximum benefit amount will be effective on the date Sun Life approves the evidence of insurability.

If you are not actively working on the date an increase in your benefits, the amount of your insurance or the amount of your dependant insurance would be effective, the increase becomes effective on the date you return to active work. Sun Life may require evidence of insurability to establish the date that you are physically and mentally fit to return to active work. If so, the increase becomes effective on the date Sun Life establishes. If Sun Life doesn't approve the evidence of insurability required, the increase will not be effective.

You may change the option elected on December first every year, every two years, if you are a member in Option 3. You may only move up or down one level at each enrolment. If you have an eligible personal status change during the plan year, you will be able to adjust your coverage immediately within 31 days of the event. Eligible status changes include:

- marriage or common-law relationship;
- birth, adoption or gaining legal custody of a child;
- the gain or loss of benefits coverage through a spouse's employer;
- divorce or legal separation;
- death of a dependant.

Subrogation

Subrogation is a legal practice giving Sun Life the right to be reimbursed for benefits paid to you if you have been compensated by another person who is responsible for your loss. The intent of subrogation is to limit your benefit payments to the amount you actually lost.

Let's assume a person is responsible for your disability, and is required to compensate you for any of the loss that results from your disability. If Sun Life is paying or has paid your loss of income benefits, you may be receiving more income than you earned before you became disabled. In that case, you would reimburse Sun Life for the loss of income benefits Sun Life has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Sun Life.

Subrogation also applies to any medical and/or dental expenses you have been paid as a result of an injury caused by another person. Once you are compensated by the person who is responsible for your loss, you must reimburse Sun Life.

If subrogation applies to your claim, Sun Life will contact you to obtain the information required to proceed. You will be required to sign an undertaking to reimburse Sun Life for any amount recovered which exceeds 100% of income or expenses. Before agreeing to a settlement of your claim, Sun Life's approval must be obtained.

Comparable Coverage

If you are insured for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you will be insured for the similar coverage provided by this plan.

If your dependant is insured for comparable coverage under another plan, you may decline the dependant coverage for the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops, you may request the similar coverage offered under this plan.

The insurance that replaces the comparable coverage is effective on the date that the comparable coverage stops.

If you request the dependant coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life. The insurance that replaces the comparable coverage is effective on the date that Sun Life approves the evidence of insurability. If Sun Life does not approve evidence of insurability required, the insurance will not be effective.

Termination of Insurance

Your insurance terminates on the date that you no longer meet all of the conditions for Eligibility. Your dependant insurance terminates on the date he no longer meets all of the conditions for eligibility for dependant insurance. If you, due to disease or injury, no longer meet all of the conditions, your insurance may be continued, subject to approval from Schenker of Canada Limited, until the date of termination of the insurance that is specified by Schenker of Canada Limited.

Your insurance terminates on the date a work stoppage begins unless Schenker of Canada Limited has made special arrangements with Sun Life before that date to continue some or all of the insurance. However, your Long Term Disability Insurance will be continued during the notice period for termination of employment as required by relevant legislation.

If you fail to tell Sun Life every fact material to your insurance or misrepresents those facts, that insurance is voidable.

Statements made on your enrolment form or on an evidence of insurability form that are fraudulent or a misstatement of age may be contested at any time.

Other statements are incontestable 2 years after the statements are made.

Basic and Optional Life Insurance Provision for Employees

Benefit

The amount of benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or if the beneficiary has predeceased you, payment will be made to your estate.

No benefit is payable for any amount of Optional Life Insurance that has been in force for less than 2 years if death is due to suicide, regardless of whether you have a mental illness or intend or understand the consequences of your actions.

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.

If you become totally disabled before age 65, your Life Insurance may be continued. Premiums for the continued insurance will be waived after you have been totally disabled from the same or related causes for six continuous months or, if you are also insured for group Long Term Disability Insurance with Sun Life, when you begin receiving group Long Term Disability payments.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. The claimant must submit proof of the claim and the right to receive the benefit to Sun Life.

If you become totally disabled and are also insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim along with your claim under the group Long Term Disability Insurance to Sun Life.

If you become totally disabled and are not insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim to Sun Life after you have been totally disabled continuously for 6 months but not beyond 12 months after the date you became totally disabled.

Limitation period for Ontario:

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

At Termination

If your Life Insurance ends for any reason other than your request, you may apply to convert the group Life Insurance to an individual Life policy with Sun Life without providing evidence of insurability.

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

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

Basic and Optional Dependant Life Insurance Provision

Benefit

The amount of benefit will be paid to you upon the death of your insured dependant.

For Optional Spouse Life Insurance, if you have appointed a beneficiary, the amount of benefit will be paid to the beneficiary upon the death of your insured spouse.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and desire to designate a minor as your spouse's beneficiary, you may wish to designate someone else to receive the death benefit in trust for the minor. If a trustee is not designated, applicable legislation may require that a death benefit payable to a minor be paid instead to a court, or guardian or public trustee. If you reside in Québec and have designated a minor as beneficiary, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively (and regardless of whether you reside outside or in Québec), you may wish to consider designating your spouse's estate as beneficiary and provide the executor(s) with directions in your spouse's will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

No benefit is payable for any amount of Optional Spouse Life Insurance that has been in force for less than 2 years if death is due to suicide, regardless of whether your insured spouse has a mental illness or intends or understands the consequences of their actions.

If you become totally disabled, your Dependant Life Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Claims

A claim must be received by Sun Life within 6 years of the date of death. You must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

At Termination

If your Dependant Life Insurance for your spouse terminates due to the termination of your Member Life Insurance, your spouse may convert the amount of the dependant insurance terminated to an individual policy on his life.

Your spouse must apply and pay the premium to Sun Life within 31 days after termination of insurance.

Where necessary in order to comply with applicable legislation: If the dependant insurance for a child terminates due to the termination of your insurance, you may convert the amount of the dependant insurance terminated to an individual policy on the child's life without submitting evidence of insurability.

The conditions that apply to the Conversion Privilege for the member's insurance will apply to the Conversion Privilege for the dependant insurance.

If your Dependant Life Insurance terminates and the dependant dies within 31 days after termination of insurance, we will pay you the amount of insurance which could have been converted to an individual policy on the dependant life's through the Conversion Privilege of this provision, or the amount stipulated in any applicable legislation, if greater.

Basic and Optional Accidental Death and Dismemberment Insurance Provision for Employees

Benefit

The amount of death benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or, if the beneficiary has predeceased you, we will pay your estate. The amount of dismemberment benefit will be paid to you.

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.

If a claim is submitted for Repatriation, we will pay your estate. If a claim is submitted for Occupational Training for Spouse, we will pay your spouse. If a claim is submitted for Education Benefit for Dependant Child, we will pay your dependent child.

Depending on the loss suffered by you, the amount of benefit is limited to the percentage shown in the Schedule of Losses.

Schedule of Losses

Loss of Life	100%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%
Loss of Both Hands, Both Feet or Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Speech and Hearing	100%
Loss of Use of Both Hands or Both Feet	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand, One Foot or Sight of One Eye	67%
Loss of Use of One Hand or One Foot	67%
Loss of Speech or Hearing	50%
Loss of Hearing in One Ear	50%
Loss of Thumb and Index Finger of One Hand	33%

Loss of Four Fingers of One Hand	33%
Loss of All Toes of One Foot	25%

If you suffer more than one of the losses listed above as a result of one accident, Sun Life will pay the amount of benefit for only one loss. That loss will be the highest of the losses suffered by you.

When proof is received by Sun Life that you have suffered any of the losses due directly to bodily injury caused solely by an accident, the amount of benefit will be paid, provided all of the following conditions are met:

- The accident must occur while you are insured under this provision.
- The loss must occur within 365 days of the date of the accident.

If you become totally disabled, your Accidental Death and Dismemberment Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Repatriation

If you suffer loss of life, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, for the preparation and transportation of your body from the place of the accident to your place of permanent residence.

The accidental death must occur at a distance of 150 kilometres or more from your place of permanent residence.

Rehabilitation

If you suffer any of the losses, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, to train you for active employment in an occupation for which you would not have engaged except for those injuries.

The expenses must be incurred within 2 years of the date of the accident.

No payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

Occupational Training for Spouse

If you suffer loss of life, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, to enrol your spouse in an accredited occupational training program to qualify him for active employment in an occupation for which he would not otherwise have sufficient qualifications.

The expenses must be incurred within 3 years of the date of the accident.

No payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

Education Benefit for Dependent Child

If you suffer loss of life, we will pay the reasonable and customary tuition expenses to enrol your dependent child as a full-time student at a post-secondary institution provided

1. your dependent child is enrolled as a full-time student at a post-secondary institution at the time of the accident, or

2. your dependent child is a student at the secondary school level and, within 365 days of the date of the accident, he enrols as a full-time student at a post-secondary institution.

The maximum amount of benefit payable for each year that your dependent child is enrolled as a full-time student at a post-secondary institution will be the lesser of:

1. 5% of your amount of benefit, or
2. $5,000.

The amount of benefit will be paid each year, up to 4 consecutive years, after we receive proof that your dependent child is enrolled as a full-time student at a post-secondary institution.

No payment will be made for:

1. tuition expenses incurred before the date of the accident.
2. room or board or other ordinary living, travelling, or clothing expenses.

A post-secondary institution includes any accredited university, colleges d'enseignement general et professionnel, trade school, community college, or private college that provides an education above the secondary school level.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. A claim for a loss must be received by Sun Life within 3 months of the date of the loss. All other claims must be received by Sun Life within 3 months of the date that the expense is incurred. The claimant must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for a loss directly or indirectly due to

1. suicide or self-inflicted injuries, regardless of whether you have a mental illness or intend or understand the consequences of your actions,
2. disease,
3. civil disorder or war, whether or not war was declared,
4. full-time service in the armed forces of any country,
5. injuries received while riding in, or on, or boarding or alighting from an aircraft if, when the injuries were received,
    a. you were operating, learning to operate or serving as a member of a crew of any aircraft, or
    b. the aircraft was being used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Optional Accidental Death and Dismemberment Insurance Provision for Spouse

Benefit

The amount of benefit will be paid to you.

For Optional Spouse Accidental Death and Dismemberment Insurance, if you have appointed a beneficiary, the amount of benefit payable as a result of your spouse's death will be paid to the beneficiary.

Depending on the loss suffered by your insured dependant, the amount of benefit is limited to the percentage shown in the Schedule of Losses.

Schedule of Losses

Loss of Life	100%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%
Loss of Both Hands, Both Feet or Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Speech and Hearing	100%
Loss of Use of Both Hands or Both Feet	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand, One Foot or Sight of One Eye	67%
Loss of Use of One Hand or One Foot	67%
Loss of Speech or Hearing	50%
Loss of Hearing in One Ear	50%
Loss of Thumb and Index Finger of One Hand	33%
Loss of Four Fingers of One Hand	33%
Loss of All Toes of One Foot	25%

If your insured dependant suffers more than one of the losses listed above as a result of one accident, Sun Life will pay the amount of benefit for only one loss. That loss will be the highest of the losses suffered by your insured dependant.

When proof is received by Sun Life that your insured dependant has suffered any of the losses due directly to bodily injury caused solely by an accident, the amount of benefit will be paid, provided all of the following conditions are met:

- The accident must occur while your dependant is insured under this provision.
- The loss must occur within 365 days of the date of the accident.

No benefit is payable for any loss suffered by an insured dependant if the loss occurs before he reaches the age of 2 years.

If you become totally disabled, your Dependant Accidental Death and Dismemberment Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Repatriation

If your dependant suffers loss of life, Sun Life will pay the reasonable and customary expenses, limited to a maximum of $10,000, for the preparation and transportation of your dependant's body from the place of the accident to his place of permanent residence.

The accidental death must occur at a distance of 150 kilometres or more from your dependant's place of permanent residence.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. A claim for a loss must be received by Sun Life within 3 months of the date of the loss. All other claims must be received by Sun Life within 3 months of the date that the expense is incurred. The claimant must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for a loss directly or indirectly due to

1. suicide or self-inflicted injuries, regardless of whether your insured spouse has a mental illness or intends or understands the consequences of their actions,
2. disease,
3. civil disorder or war, whether or not war was declared,
4. full-time service in the armed forces of any country,
5. injuries received while riding in, or on, or boarding or alighting from an aircraft if, when the injuries were received,
    a. your insured dependant was operating, learning to operate or serving as a member of a crew of any aircraft, or
    b. the aircraft was being used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Short Term Disability Insurance Provision

Benefit

Short term disability benefits are provided by the Schenker Short Term Disability Plan when you are temporarily unable to perform the normal duties of your occupation because of an illness or injury.

In the case of mental stress, you will only be entitled to recover these benefits for mental stress that does not result from an injury for which you are otherwise entitled to compensation, when that mental stress:

a. is an acute reaction to a sudden and unexpected traumatic event arising out of and in the cours e of your employment,

b. is diagnosed by a physician as a mental or physical condition that is described in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis, and

c. is not caused by a decision or action on the part of Schenker of Canada relating to your employment, including, without limiting the generality of the foregoing, a decision or action to change the terms and conditions of your employment or the work to be performed by you, to discipline you, or to terminate your employment.

Schenker's short term disability plan will maintain your salary (or a percentage thereof) for a period of time determined by the disability benefit credits to which you are entitled. Credits are awarded according to the length of service with the Company according to the following schedule:

Years of Service	Full Salary	Followed by 66 2/3%
3 months – 1year	02 weeks	24 weeks
1 year to 3 years	04 weeks	22 weeks
3 years to 5 years	06 weeks	20 weeks
5 years to 7 years	08 weeks	18 weeks
7 years to 9 years	10 weeks	16 weeks
9 years to 10 years	12 weeks	14 weeks
10 years or more	15 weeks	11 weeks

If you return to work on a full time basis and have a recurrence of the same or related disability **within three months**, sick pay will be determined as if the disability was continuous with no return to work. **After three months**, sick pay will be determined as if there had been no previous disability.

If you return to work on a full time basis and become disabled again after **one month** due to causes unrelated to the previous disability, sick pay will be determined as if there had been no previous disability.

Medical Certification of Disability

To recover short term disability benefits for an absence in excess of 3 days, your application must be supported by a note from your doctor describing the nature of your illness or injury and confirming that you are totally disabled from working because of it.

The company reserves the right to also ask for such documentation when you have been absent for less than 3 days, but in frequent intervals accumulating 5 days absence in one month.

To recover short term disability benefits for an absence in excess of 2 weeks, an evaluation by our insurance company will be performed. As a result, your application must be supported by a formal written report from your doctor and any specialist being consulted detailing the nature of your illness or injury, confirming that you are totally disabled from working because of it and providing a prognosis on the date that you will likely be able to return to work. With those report(s), there must be included, copies of the clinical notes showing the dates of your visits to the doctor(s), the treatments prescribed and any consultation reports or test results prepared.

At the request of the insurance company, we may require you to undergo an independent examination by a physician of our choice at our expense to verify the nature and extent of your disability.

Subrogation

Subrogation is a legal principle which gives Schenker the right to be reimbursed for benefits it pays to you when another person has caused your illness or disability. Schenker's right of subrogation not only entitles it to be repaid the short term disability benefits which it has paid when you recover damages from such a third party, but to pursue your legal rights and remedies against such third party in your name if it chooses to do so.

Let's assume another person has caused you to be disabled from working, and is required to compensate you for your losses. If Schenker has paid or is paying you short term disability benefits, you may receive more income while disabled from work than you would have earned if not disabled. In that case, the principle of subrogation requires you to reimburse Schenker for the loss of income benefits Schenker has paid. If you receive money from a third party for future loss of income, that amount recovered would reduce the amount of future short term disability benefits to be paid by Schenker.

If subrogation applies to your claim for benefits, you must keep Schenker fully advised of the incident which gives rise to the illness or disability, and the steps you take or could take to recover the loss from a third party. As a condition of paying you the benefits, Schenker will require you to sign an undertaking to reimburse Schenker for any amount recovered from the third party or their insurer which exceeds 100% of the income or expenses which you would have lost but for the Schenker benefit program. Before agreeing to settle your claim against the third party, you must obtain Schenker's approval and consent.

Long Term Disability Insurance Provision

Qualifying for Monthly Disability Benefits

You qualify for benefits when Sun Life receives proof that:

1. you are absent from active work because you are totally disabled,
2. you are totally disabled for as long as the qualifying period, and
3. you are under the active and continuous care of a physician whom Sun Life considers to be appropriate to your total disability and you are following the treatment prescribed by that physician.

Your Monthly Disability Benefit

Your monthly disability benefit is calculated as shown on the Summary of Insurance at the front of this booklet.

Income to which you are entitled under a government plan will reduce your monthly disability benefit unless Sun Life receives proof that the initial application and an appeal, or a later re-application required by Sun Life, have been declined.

Increases in the disability income payable under a government plan may occur because of an automatic adjustment in the cost of living. These increases will not further reduce your monthly disability benefit.

The total income you receive from all sources will not be less than your monthly disability benefit.

Your monthly disability benefit will not be reduced by any disability or retirement income you receive from the following sources:

1. a policy which is solely an individual disability income policy.
2. a disability attachment to an individual life insurance policy.
3. a retirement income plan providing income that becomes payable before you become totally disabled.

Rehabilitation

If your total disability prevents you from returning to work, Sun Life may be able to assist you by providing a rehabilitation program that will help you return to the workforce. A rehabilitation program is limited to one or more of the following:

1. assessment,
2. counselling,
3. vocational retraining or an educational program,
4. trial work, part-time or modified work.

If, after qualifying for benefits, you are receiving income from an approved rehabilitation program, your monthly disability benefit is reduced by 50% of that income. Your monthly disability benefit is further reduced so that the total income from all sources does not exceed 100% of your

- gross monthly earnings in force on the date you became totally disabled, if the benefit is subject to income tax, or

- net monthly earnings, in force on the date you became totally disabled, if the benefit is not subject to income tax.

Example:
Assume you are earning $2,000/month and have a 66 2/3% LTD benefit ($1,334.00). Rehabilitation income from your employer is $1,000/month. There is no income from other sources.

Rehabilitation Income + (Monthly Disability Benefit - 50% of Rehabilitation Income)
= $1,000 + ($1,334.00 - {50% of $1,000})
= $1,000 + $834.00
= $1,834.00

Since the benefit ($1,834.00/month) does not exceed your pre-disability monthly earnings ($2,000/month), there will be no reductions due to the 100% all source maximum.

If you are participating in a rehabilitation program approved by Sun Life, you continue to be considered totally disabled.

Payment of Monthly Disability Benefit

The monthly disability benefit will be paid to you when proof is received by Sun Life that you are absent from active work because you are totally disabled. Benefits are paid in arrears and will begin one month after you become eligible to receive them. You will receive one-thirtieth of the monthly disability benefit for each full day you are totally disabled following the qualifying period.

Benefits are payable from the latest of

- the end of the qualifying period,
- the date you are no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan, or
- the date you are no longer entitled to receive severance pay, payments in lieu of severance pay and damages, or settlements for wrongful dismissal.

If you become totally disabled, your Long Term Disability Insurance may be continued without payment of premiums while you are eligible to receive Long Term Disability benefit payments.

Survivor Benefit

If you die while receiving Long Term Disability Benefit payments, a survivor benefit will be paid to your designated beneficiary. The benefit is equal to 3 times your last monthly disability payment.

Claims

A claim must be received by Sun Life within 3 months after the end of the qualifying period. The qualifying period begins on the date you become totally disabled. Proof of continuing total disability may be required as often as necessary.

If you are receiving Workers' Compensation, Workplace Safety Insurance Act or similar legislation’s benefits, you must submit a claim for the monthly disability benefit.

There is a time limit for appealing Sun Life's decision to decline or terminate a claim. An appeal must be made within 3 months of such a decision and must be accompanied by new objective medical evidence.

Limitation period for Ontario:

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

At Termination

If the Long Term Disability provision terminates while you are totally disabled, you will continue to be eligible for this benefit as if it were still in force.

Exclusions and Limitations

No benefit is payable for a total disability due to or related to

- intentionally self-inflicted injuries,
- civil disorder or war, whether or not war was declared.

Extended Health Insurance Provision

Benefit

To qualify for the Extended Health coverage, you or your dependant must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

Reference to Physician may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a physician. For drugs, refer to *Other health professionals allowed to prescribe drugs.*

You will be reimbursed when you submit proof to Sun Life that you or your insured dependant have incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. The total amount of eligible expenses you submit to Sun Life as a claim will be adjusted as follows:

1. the deductible, which is an amount that you must pay each calendar year, is subtracted,
2. the reimbursement percentage, which is the percentage of the eligible expense submitted that Sun Life will pay, is applied, and
3. the maximum is applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.

2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

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

Claims

A claim must be received by Sun Life within 18 months of the date that the expense is incurred. However, if your coverage terminates, any claim must be received by Sun Life no later than 90 days following the end of the coverage.

For the assessment of a claim, itemized bills, attending physician statements or other necessary information are required.

If your physician is recommending medical treatment that is expected to cost more than $1,000, you should request pre-authorization to ensure that the expenses are covered.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,

- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
- expenses for 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*,
- expenses for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

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 or your dependant have made an application to the government program,
- whether coverage under this plan affects your or your dependant's eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

At Termination

If, on the date of termination of your insurance,

- you have a medically determinable physical or mental impairment due to injury or disease which prevents you from performing the regular duties of the occupation in which you participated just before the impairment started, regardless of the availability of work for you, or
- your insured dependant has a medically determinable physical or mental impairment due to injury or disease, is receiving treatment from a physician and is confined to a hospital or his home,

benefits will be payable for eligible expenses related to the impairment provided they are incurred within 90 days of the date of termination and this provision continues in force.

If you die, your insured dependant's Extended Health Insurance Benefits will be continued for 24 months without payment of premiums as long as the Extended Health Insurance provision remains in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

Health Coverage Choice

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

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

- apply for My Health CHOICE coverage within 60 days after the termination of your coverage,
- be under age 75 on the date you apply, and
- be a resident of Canada and be covered under the provincial health plan.

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

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

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

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

Extended Health – Pay Direct Drug Benefit (Option 2)

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*. There are additional eligibility requirements that apply, see *Prior authorization program* for details.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
6. drugs used for the treatment of infertility, limited to a lifetime maximum of $5,000.
7. zyban, limited to a lifetime maximum of $500 for you and for each insured dependant.

Drug evaluation

The following drugs will be evaluated and must be approved by Sun Life to be eligible for coverage:

1. drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
2. 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 Sun Life's approval.

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

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

Pharmaceutical services (rendered by pharmacists) – Sun Life will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

Drug Substitution

For members and insured dependants who live in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, if the prescribed drug has a lower priced equivalent drug, charges in excess of the lowest priced equivalent drug may not be considered when calculating the reimbursement, unless Sun Life specifically approved the charges for the higher priced drug. To assess the medical necessity of a higher priced drug, Sun Life will require the insured person and the attending doctor to complete and submit an exception form. Charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless Sun Life specifically approved the charges for the higher priced drug.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your insured dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Régie de l'assurance-maladie du Québec (RAMQ) Formulary Drugs for Québec Residents

In addition to the above eligible expenses, this benefit includes all drugs covered by Québec's basic drug formulary, as established by the RAMQ. The minimum reimbursement percentage required by provincial legislation is applied up to the annual out-of-pocket maximum, as specified by law. This formulary is reviewed on a regular basis and is subject to change as new drugs and drug products are introduced.

For Québec residents, any maximums included in this benefit do not apply to eligible drugs covered by the RAMQ formulary.

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 the insured person submits a claim for a drug included in the PA program and has not been pre-approved, the claim will be declined.

In order for drugs in the PA program to be covered, the insured person needs to provide medical information using Sun Life's PA form. Both the insured person and the attending physician need to complete parts of the form.

The insured person will be eligible for coverage for these drugs if the information provided by the insured person and the attending physician meets Sun Life's 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.
- the insured person's response to preferred drug therapy.

If not, the claim will be declined.

The prior authorization forms are available from the following sources:

1. Sun Life's website at www.mysunlife.ca/priorauthorization
2. Sun Life's Customer Care centre by calling toll-free 1-800-361-6212

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
3. expenses for drugs which, in Sun Life's opinion, are experimental,
4. expenses for dietary supplements, vitamins and infant foods,
5. expenses for contraceptives (other than oral),
6. expenses for drugs which are used for cosmetic purposes,
7. expenses for drugs used for the treatment of sexual dysfunction,
8. expenses for drugs used for the treatment of obesity,
9. expenses for smoking cessation aids, other than Zyban,
10. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
11. expenses for 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, and
12. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Pay Direct Drug Benefit (Option 3)

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*. There are additional eligibility requirements that apply, see *Prior authorization program* for details.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
6. drugs used for the treatment of infertility, limited to a lifetime maximum of $5,000.
7. zyban, limited to a lifetime maximum of $500 for you and for each insured dependant.

Drug evaluation

The following drugs will be evaluated and must be approved by Sun Life to be eligible for coverage:

1. drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
2. 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 Sun Life's approval.

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

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

Pharmaceutical services (rendered by pharmacists) – Sun Life will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

Drug Substitution

For members and insured dependants who live in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, if the prescribed drug has a lower priced equivalent drug, charges in excess of the lowest priced equivalent drug may not be considered when calculating the reimbursement, unless Sun Life specifically approved the charges for the higher priced drug. To assess the medical necessity of a higher priced drug, Sun Life will require the insured person and the attending doctor to complete and submit an exception form. Charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless Sun Life specifically approved the charges for the higher priced drug.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your insured dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Régie de l'assurance-maladie du Québec (RAMQ) Formulary Drugs for Québec Residents

In addition to the above eligible expenses, this benefit includes all drugs covered by Québec's basic drug formulary, as established by the RAMQ. The minimum reimbursement percentage required by provincial legislation is applied up to the annual out-of-pocket maximum, as specified by law. This formulary is reviewed on a regular basis and is subject to change as new drugs and drug products are introduced.

For Québec residents, any maximums included in this benefit do not apply to eligible drugs covered by the RAMQ formulary.

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 the insured person submits a claim for a drug included in the PA program and has not been pre-approved, the claim will be declined.

In order for drugs in the PA program to be covered, the insured person needs to provide medical information using Sun Life's PA form. Both the insured person and the attending physician need to complete parts of the form.

The insured person will be eligible for coverage for these drugs if the information provided by the insured person and the attending physician meets Sun Life's 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.
- the insured person's response to preferred drug therapy.

If not, the claim will be declined.

The prior authorization forms are available from the following sources:

1. Sun Life's website at www.mysunlife.ca/priorauthorization
2. Sun Life's Customer Care centre by calling toll-free 1-800-361-6212

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
3. expenses for drugs which, in Sun Life's opinion, are experimental,
4. expenses for dietary supplements, vitamins and infant foods,
5. expenses for contraceptives (other than oral),
6. expenses for drugs which are used for cosmetic purposes,
7. expenses for drugs used for the treatment of sexual dysfunction,
8. expenses for drugs used for the treatment of obesity,
9. expenses for smoking cessation aids, other than Zyban,
10. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
11. expenses for 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, and
12. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Vision Benefit

Definitions

Ophthalmologist
means a person licensed to practise ophthalmology.

Optometrist
means a member of the Canadian Association of Optometrists or of a provincial association associated with it.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense:

1. eye examinations by an ophthalmologist or optometrist limited to one examination in a 24 month period.
2. eyeglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Insurance for eligible expenses incurred during a 24 month period for you and each insured dependant.
3. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to a lifetime maximum of $200 for the non-surgical treatment of keratoconus for you and for each insured dependant and a maximum of $200 for expenses incurred within six months of each surgical procedure.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Hospital Benefit (Option 2)

Definitions

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses are for the items listed below:

1. reasonable and customary charges for accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.
2. reasonable and customary charges for semi-private room and board accommodation for convalescent care (not custodial care) provided in a licensed hospital, limited to $25 per day.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Hospital Benefit (Option 3)

Definitions

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses are for the items listed below:

1. reasonable and customary charges for accommodation in a hospital, limited to the difference between the charges for public ward and private room for each day of hospitalization.
2. reasonable and customary charges for private room and board accommodation for convalescent care (not custodial care) provided in a licensed hospital, limited to $25 per day.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Supplementary Health Care Benefit

Definitions

Acupuncturist
means a person who is listed on the appropriate provincial registry.

Chiropodist, Podiatrist
means a person licensed by the appropriate provincial licensing authority.

Chiropractor
means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.

Clinical counsellor
means a person who is an active member of a provincial association which is approved by Sun Life.

Hospital
means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Naturopath
means a member of the Canadian Naturopathic Association or any provincial association affiliated with it.

Osteopath
means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association or a person who holds a Diploma in Osteopathic Manual Practice (DOMP).

Physiotherapist
means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.

Psychologist
means a permanently certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.

Psychotherapist
means a person licensed by the appropriate provincial licensing authority as a psychotherapist, or a person who is an active member of a provincial psychotherapy association approved by Sun Life.

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Massage Therapist

means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications we determine to be comparable with those required by a licensing body.

Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant, Licensed Practical Nurse

means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Social Worker

means a person who holds a Master of Social Work (MSW) degree from an accredited university.

Speech Language Pathologist

means a person who holds a master's degree in Speech Language Pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or bodily injury and prescribed by a physician.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.), registered nursing assistant (R.N.A.), certified nursing assistant (C.N.A.) or licensed practical nurse (L.P.N.) when provided in the patient's home, limited to a calendar year maximum of $10,000. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A., or L.P.N.
2. the services of the following practitioners, limited to a combined calendar year maximum of $750 for option 2, $1,000 for option 3.
   a. an acupuncturist*,
   b. a registered massage therapist*,
   c. a chiropractor*, including one x-ray examination per calendar year,
   d. an osteopath*, including one x-ray examination per calendar year,
   e. a naturopath*,
   f. a podiatrist or chiropodist*, including one x-ray examination per calendar year,
   g. a speech language pathologist*, and
   h. a physiotherapist*.

   *physician's prescription not required.

   The practitioner must be registered with the appropriate association or registry. Where applicable, expenses for practitioners' services eligible under a provincial health care plan will not be reimbursed until your expenses exceed the annual maximums under your provincial plan.

3. the services of a psychologist*, social worker*, clinical counsellor* or psychotherapist*, limited to a combined maximum of $1,000 in a calendar year. *physician's prescription not required.
4. the services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 12 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident. A physician's prescription is not required.
5. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
6. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.
7. orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use, limited to one pair per calendar year and not exceeding $400 in a calendar year.
8. hearing aids and repairs to them, excluding batteries, limited to $500 for option 2, $600 for option 3 for eligible expenses incurred during a 4 year period.
9. trusses and crutches.
10. plaster of paris or fibreglass casts.
11. braces, provided they are not solely for athletic use.
12. artificial limbs or other prosthetic appliances.
13. oxygen.
14. diagnostic laboratory and x-ray examinations.
15. blood glucose monitors, limited to $150 for eligible expenses incurred during a 5 year period.
16. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
17. rental, or purchase at Sun Life's option, of medically necessary durable equipment that meets the patient’s basic medical needs and is approved by Sun Life. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:
    a. wheel chairs,
    b. wheel chair repairs, limited to a lifetime maximum of $250,
    c. walkers,
    d. hospital beds,
    e. traction kits.
18. the following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence.
    a. public ward accommodation and auxiliary hospital services in a general hospital limited to, after deducting the amount payable by a government plan, $75 a day for 60 days in a calendar year.
    b. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

Items of expense incurred outside Canada are eligible only if they are not offered in any province in Canada.

19. Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, limited to a combined maximum of $4,000 in a calendar year. You must provide Sun Life with a physician's note confirming the diagnosis.

Exclusions

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the use of a service,
5. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Gender affirmation procedures

1. the following gender affirmation procedures, limited to a benefit year maximum of $10,000 and a lifetime maximum of $50,000, provided the insured person meets the *Eligibility Requirements* set out below.

   Surgical and other procedures for male-to-female transition:

   a. augmentation mammoplasty.
   b. thyroid chondroplasty.
   c. laryngoplasty.
   d. permanent hair removal (laser or electrolysis) for pre-surgical areas in preparation for vaginoplasty, or for excessive facial or body hair.
   e. brow bone reduction; jaw bone reduction/reshaping/contouring; rhinoplasty; blepharoplasty; rhytidectomy; liposuction of the waist; gluteal augmentation (lipofilling or implants).
   f. hairline reconstruction to correct a receding hairline.

   Surgical and other procedures for female-to-male transition:

   a. scrotoplasty.
   b. implantation of penile and/or testicular prostheses.
   c. permanent hair removal (laser or electrolysis) for pre-surgical areas in preparation for phalloplasty.
   d. brow bone construction; chin augmentation; cheek augmentation; rhinoplasty; blepharoplasty; chest contouring (liposuction/lipofilling); pectoral implants.

   Sun Life reserves the right to modify the above list of eligible expenses in the event there is a change in the list of procedures covered by any of the gender affirmation programs in a province or territory.

Eligibility Requirements

- The insured person must be under the care of a physician for gender transitioning.
- The insured person must be at least 18 years old.
- Prior approval is required. The *Gender Affirmation application form* must be completed by the insured person and the attending physician, and submitted to Sun Life along with proof that the insured person has been approved for surgical procedure(s) under the medicare plan's gender affirmation program in the person's place of residence.
  If the insured person lives in a province or territory which does not have a gender affirmation program, the person will need to contact Sun Life and meet Sun Life's criteria in order for expenses to be eligible for reimbursement.
- All procedures must be considered medically necessary by the attending physician.
- All procedures must be performed in Canada.
- Only expenses incurred after the person's effective date for insurance under this benefit provision, and while this benefit provision is in force, will be eligible for reimbursement.

Before incurring an expense, the insured person must call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212 to obtain the *Gender Affirmation application form*. Sun Life will assess all procedures based on the terms of this plan. Sun Life reserves the right to request details of procedures performed.
The insured person may incur other expenses, such as drugs or paramedical services, related to gender transitioning. To determine if these other expenses are eligible under this plan, and any applicable benefit maximum, please refer to the *Drug Benefit*, *Supplementary Health Care Benefit* or other applicable provisions of this Extended Health insurance.

Exclusions

Sun Life will not pay for the costs of:

- procedures payable or available under the medicare plan in the insured person's place of residence.
- travel or accommodations expenses.
- reversal of gender affirmation procedures.
- sperm preservation or cryopreservation of fertilized embryos *(covered under Extended Health – Pay Direct Drug Benefit)*.
- procedures related to fertility problems caused by gender transitioning.

Extended Health – Out-of-Province Emergency and Travel Assistance Benefit

To be insured for this benefit, you and your insured dependant must have provincial health care coverage. Expenses for hospital/medical services and travel assistance benefits are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside your home province,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 6 months of travelling on vacation or business outside your home province. Your 6 months of coverage starts on the day you or your insured dependant departs from your home province.

Definitions

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

Emergency services
mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your insured dependant have a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Family member
means you or your insured dependant.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Relative
means your spouse, parent, child, brother or sister.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact our 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 we have the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the family member is medically stable to return to his province of residence.

Emergency Services Excluded from Coverage

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

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that we or Allianz Global Assistance, based on available medical evidence, determines that the family member can be returned to his province of residence, and he refuses to return.
4. services which are required for the same illness or injury for which the family member received emergency services, including any complications arising out of that illness or injury, if the family member had unreasonably refused or neglected to receive the recommended medical services.
5. 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.

Eligible Expenses for Hospital/Medical Services

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services, less the amount payable by a government plan:

1. public ward accommodation and auxiliary hospital services in a general hospital,
2. services of a physician,
3. economy air fare for the patient's return to his province of residence for medical treatment,
4. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation,
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

The maximum lifetime amount payable for the above Eligible Expenses is $1,000,000 for you and for each insured dependant.

Expenses that are included as Eligible Expenses under Drug, Vision, Hospital or Supplementary Health Care benefits are also eligible while you or your insured dependant is travelling outside Canada. These expenses are subject to the deductibles and reimbursement percentages listed under the appropriate benefit in the Summary of Insurance.

Eligible Expenses for Travel Assistance Benefits

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services:

1. family assistance benefits, which include reimbursement for the cost of:
   a. return transportation for insured dependent children who are under the age of 16, or who are handicapped, if they are left unattended because you or your spouse is hospitalized outside your province of residence. Sun Life will arrange the transportation of the dependent child to your home, and if necessary, an escort will be provided to accompany him. The maximum payable for the return transportation is a one-way economy fare for each dependent child.
   b. return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
   c. visit of one relative, if a family member is hospitalized for more than 7 days while travelling without a relative. This includes meals and accommodation up to a maximum of $150 per day, and round-trip economy transportation, for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of his body.
   d. meals and accommodation up to a maximum of $150 per day per family, if a trip is extended because a family member is hospitalized.

   The combined maximum amount payable for the above family assistance benefits is $5,000 for one travel emergency.
2. return of a deceased family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. The maximum amount payable for the preparation and return of the deceased is $5,000. Preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased **includes** a basic shipping container, but **excludes** expenses for burial, such as burial caskets and urns.
3. return of a vehicle. If a family member is unable to operate a vehicle (owned or rented) because he is being returned to Canada for medical treatment, Sun Life will reimburse the cost of returning this vehicle to his province of residence, or the nearest appropriate rental agency. This benefit is also payable in the event of a family member's death. The maximum amount payable for returning the vehicle is $1,000.

Travel Assistance Services

Out-of-province and around-the-world services are provided through Allianz Global Assistance, a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Allianz Global Assistance will be able to provide you and your insured dependants with the following emergency assistance services during the first 6 months of travel:

1. physician and hospital referrals,
2. on-going monitoring of medical treatment if a family member is hospitalized,
3. coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer him to another hospital that is equipped to provide the required treatment,

4. payment assistance for hospital/medical expenses,
5. legal referrals,
6. a telephone interpretation service,
7. a message service for you, your family, friends and business associates.

Emergency Payment Assistance

Eligible Hospital/Medical Expenses:

To ensure payment of these expenses,

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Sun Life Travel card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Allianz Global Assistance will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your insured dependant.
3. You will be required to sign an authorization form allowing Allianz Global Assistance to recover any amounts payable by the provincial health care plan.
4. For expenses that require a percentage paid by you, or that are not covered under this plan or the provincial health care plan, you must reimburse Sun Life for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Allianz Global Assistance and they will coordinate payments with the provincial health care plan and Sun Life.

24 Hour Helpline

If emergency assistance is needed, a 24 hour helpline is available. Multilingual coordinators at Allianz Global Assistance can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The 24 hour helpline can assist you and your insured dependant if you have lost your passport or visa, if you need to find a local legal advisor, or if you require telephone interpretation services. You can also call the helpline and leave important messages for family, friends or business associates; likewise, they can call the helpline and leave messages for you while you travel. Allianz Global Assistance will hold such messages for 15 days.

When calling the 24 hour helpline, please be ready to state your Policy No., Certificate No., ID No., and Provincial Medical Insurance Plan/Health Card Number.

Please consult the telephone numbers on your Travel card.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your insured dependant due to an emergency which occurs more than 6 months after departure from your province of residence,
2. expenses incurred on a non-emergency or referral basis,

3. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Insurance Provision.

If you are covered as a retired employee, you and your insured dependants must return to your province of residence for at least 30 consecutive days before becoming eligible for another 6 months of coverage.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries. For more information on travelling conditions and the availability of Allianz Global Assistance services in a particular country, please call the appropriate 24 hour helpline.

Neither Sun Life nor Allianz Global Assistance is responsible for the availability, quality or results of the medical treatment received by you or your insured dependant, or for the failure to obtain medical treatment.

Dental Insurance Provision

Benefit

You will be reimbursed when you submit proof to Sun Life that you or your insured dependant has incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows :

1. the deductible, which must be satisfied each year, is subtracted,
2. the reimbursement percentage is applied, and
3. the maximums specified in the Summary of Insurance are applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

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

Claims

A claim must be received by Sun Life within 18 months of the date the expense is incurred. However, if your coverage terminates, any claim must be received by Sun Life no later than 90 days following the end of the coverage.

For the assessment of a claim, itemized bills, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other necessary information may be required.

If your dentist has recommended dental treatment that is expected to cost more than $500, or if your dentist has recommended dental treatment involving dentures, bridges or crowns, you may have your dentist prepare a pre-treatment plan that you can submit to Sun Life before you start treatment. For any other dental treatment, you can call Sun Life at 1-800-361-6212 to determine if the recommended dental treatment is eligible for payment.

Limitation period for Ontario:

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

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with. Laboratory charges are also limited to 66 2/3% of the fee for the procedure in the Dental Fee Guide shown on the Summary of Insurance.

At Termination

If you die, your insured dependant's Dental Insurance Benefits will be continued for 24 months without payment of premiums as long as the Dental Insurance provision remains in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

Dental Insurance Provision – Diagnostic/Preventive Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examination and diagnosis
   - oral examination,
   - limited examination,
   - recall examination (once every 6 months for persons under 19 years of age and once every 9 months for persons 19 years of age and over),
   - limited periodontal examination (once every 6 months),
   - special oral examination,
   - treatment planning,
   - minor emergency treatment,
   - consultation,
   - house call, institutional call and office visit,

b. tests and laboratory examinations
   - biopsy of oral tissue,
   - pulp vitality tests,

c. radiographs
   - complete series (once every 36 months),
   - periapical,
   - occlusal,
   - bitewing (once every 12 months),
   - extraoral,
   - sialography,
   - radiopaque dyes to demonstrate lesions,
   - panoramic (once every 36 months),
   - interpretation of radiographs received from another source,
   - tomography

d. preventive services
   - dental polishing (once every 6 months for persons under 19 years of age and once every 9 months for persons 19 years of age and over),

- topical application of fluoride phosphate (once every 6 months for persons under 19 years of age),
- pit and fissure sealants (for persons under 19 years of age),
- interproximal discing,
- recontouring of teeth for functional reasons

e. space maintainers (for persons under 15 years of age)

f. drug injections

g. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses for replacement of space maintainers which have been lost, stolen or mislaid,
4. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
5. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Restorative Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. restorations
   - caries control,
   - trauma control,
   - amalgam,
   - acrylic or composite resin,
   - prefabricated restorations (for persons under 15 years of age)

b. periodontics
   - non surgical services,
   - occlusal adjustment/equilibration (not exceeding 8 time units every year)
   - scaling and root planing (not exceeding 10 time units each year),

c. denture repairs

d. relining and rebasing of dentures

e. surgical services
   - uncomplicated removals,
   - surgical removals and repositioning
   - surgical excision,
   - surgical incision,
   - fractures,
   - lacerations,
   - frenectomy,
   - miscellaneous surgical services,

f. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

g. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Orthodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense

a. observation, adjustment
   - oral examination,
   - skull and facial bone survey,
   - cephalometric radiographs,
   - hand and wrist radiographs,
   - diagnostic cast,
   - surgical services,
   - observation, adjustment,
   - repairs, alterations,
   - active appliances for tooth guidance or uncomplicated tooth movement
   - retention appliances,

b. control of oral habits
   - appliances
   - adjustments, repairs, maintenance

c. comprehensive treatment

d. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for replacement of orthodontic appliances which have been lost, stolen or mislaid.
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Periodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. periodontics
   - surgical services,
   - post-surgical treatment,
   - adjunctive procedures,
   - post treatment evaluation,

b. major surgery
   - alveoloplasty,
   - enucleation of cyst,
   - dislocations,

c. x-rays
   - temporomandibular joint x-rays,

d. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement of periodontal appliances which have been lost, stolen or mislaid,
3. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Denture Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. partial and complete dentures
- complete dentures,
- partial dentures,

b. remakes and adjustments
- adjustment to dentures,
- remake partial dentures,

c. examinations
- oral examination,
- diagnostic casts,

d. laboratory procedures

Replacement of an existing denture or bridgework with a denture, is an eligible expense if the replacement is required to replace an existing denture which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to an existing partial denture is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependant is insured under this benefit.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for initial dentures to replace a tooth or teeth missing before you or your insured dependant became insured under this benefit or to replace a tooth or teeth congenitally missing,
3. expenses for replacement dentures which have been lost, stolen or mislaid,
4. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
5. expenses for replacement of dentures and addition of teeth to existing dentures except as provided under Eligible Expenses,
6. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Bridge Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. hemisection
b. fixed bridgework
   - bridge pontics,
   - retainers,
   - other prosthetic services,
c. repairs and adjustments
   - porcelain repairs,
   - repairs to bridges,
d. examinations
   - oral examination,
   - diagnostic casts,
e. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia,
   - deep sedation,
   - conscious sedation,
f. laboratory procedures

Replacement of an existing denture or bridgework with bridgework is an eligible expense if the replacement is required to replace an existing denture or bridgework which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to existing bridgework is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependant is insured under this benefit.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for initial bridgework (including crowns and inlays forming the retainers) to replace a tooth or teeth missing before you or your insured dependant became insured under this benefit or to replace a tooth or teeth congenitally missing,
3. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,

4. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
5. expenses for replacement of bridgework and addition of teeth to existing bridgework except as provided under Eligible Expenses,
6. expenses for permanent splinting,
7. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
8. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Crown Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. crowns, inlays, onlays
   - metal inlay restorations,
   - composite inlay restorations,
   - porcelain/ceramic inlay restorations
   - crowns,
   - other restorative services,

b. repairs and adjustments
   - porcelain repairs,
   - recementing crowns,

c. examinations
   - oral examination,
   - diagnostic casts,

d. laboratory procedures

Replacement of an existing crown, inlay or onlay is an eligible expense if the replacement is required to replace an existing crown, inlay or onlay which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original crown, inlay or onlay.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
4. expenses for replacement of crowns, inlays or onlays except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Endodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. endodontics
   - pulpotomy,
   - root canal therapy,
   - periapical services,
   - other endodontic procedures,
   - emergency procedures,

b. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

c. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Health Spending Account – For Members who choose Option 1 Extended Health and Dental

General Description of the Benefit

Schenker of Canada Limited has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of Schenker of Canada Limited.

Your Health Spending Account coverage pays for services or supplies described in this section under Eligible expenses.

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

A dependant is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

How your Health Spending Account Works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account as specified in the Summary.

Each time you submit a Health Spending Account claim, either for yourself or for a dependant, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one calendar year cannot be covered by credits received in the following calendar year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the calendar year following the calendar year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Benefits for Dependants After Termination

The Health Spending Account is set up under the member's name, and there cannot be any continuation of coverage for dependants after the member's death. Only expenses incurred before the member's death can be covered under the member's Health Spending Account.

Eligible Expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act of Canada **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act of Canada is changed, this plan is automatically updated to reflect the changes.

Drugs

- drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses

- eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances

- deductible and coinsurance amounts under medical or dental plans.

Licensed practitioners (fee for services)

- acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapeutists.

Dental care

- preventative, diagnostic, restorative, orthodontic and therapeutic care.

Attendant care

- remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.
- remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.

Facilities

- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.
- payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.

Hospitals

- payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.
- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of $1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.

- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
- costs of medical services and supplies outside of the province of residence.
- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.

- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
  - equivalent medical services are not available locally.
  - the route is reasonably direct.
  - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Co-ordination of Benefits

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

Claims

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

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

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

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).