

your **group**
benefits

The Toronto Terminals Railway Company Limited

Union employees of Unifor (Agreement 5.32) - TTR

**Contract Number 107305 and GPA 9426795
Effective January 1, 2025 (Version 2)**

The Basic Accidental Death and Dismemberment benefit is insured by
AIG Insurance Company of Canada

Table of Contents

Benefit Summary	1
General Information	5
About this booklet	5
Eligibility	5
Who qualifies as your dependent	6
Enrolment.....	6
When coverage begins	7
Changes affecting your coverage	7
Updating your records.....	8
Accessing your records	8
When coverage ends	9
Replacement coverage	10
Making claims.....	10
Legal actions	10
Proof of disability.....	11
Medical examination.....	12
Recovering overpayments	13
Assignments	13
Definitions.....	13
Extended Health Care (Medicare Supplement)	14
Insurer	14
General description of the coverage.....	14
Benefit year	14
Deductible	14
Lifetime maximum.....	15
Hospital expenses in your province.....	19
Expenses out of your province	20
Medical services and equipment	22
Gender affirmation procedures.....	25
Paramedical services	26
Vision care	27
Payments after coverage ends	27
What is not covered.....	28
Integration with government programs	29
When and how to make a claim	29

Emergency Travel Assistance	30
Insurer	30
Dental Care.....	36
Insurer	36
General description of the coverage.....	36
Benefit year	36
Deductible	37
Benefit year maximum	37
Lifetime maximum.....	37
Predetermination	37
Preventive dental procedures	37
Basic dental procedures.....	38
Major dental procedures.....	39
Orthodontic procedures.....	40
Payments after coverage ends	40
What is not covered.....	40
When and how to make a claim	42
Short-Term Disability (Weekly Indemnity).....	43
Insurer	43
General description of the coverage.....	43
When disability payments begin	43
Interrupted periods of disability	44
What we will pay	44
Maternity / parental leave of absence.....	47
Rehabilitation program.....	47
If you recover damages from another person	48
When payments end	48
Payments after coverage ends	49
What is not covered.....	49
When and how to make a claim	50
Life Coverage.....	51
Insurer	51
General description of the coverage.....	51
What we will pay	51
Who we will pay	51
Suicide.....	51
Coverage during total disability	52
Converting Life coverage.....	53
When and how to make a claim	53

Occupational Accidental Death.....	54
Insurer	54
General description of the coverage	54
What we will pay	54
Limit on benefit amounts	54
Repatriation benefit	54
Spouse occupational training benefit	54
Child education benefit	55
Family transportation benefit	55
What is not covered.....	55
When and how to make a claim	56
 Basic Accidental Death and Dismemberment.....	 57
Insurer	57

Benefit Summary

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

In this section, you will find the coverage which is available to you under each benefit. For more information on each benefit, please refer to the appropriate section in this booklet.

Extended Health Care

Benefit year	January 1 to December 31
Deductible	For prescription drugs there is a deductible of \$2.50 for each prescription or refill. For other expenses, there is a deductible of \$25 each benefit year for each person up to a maximum of \$25 per family. After this deductible has been paid, claims will be paid up to the percentage of coverage under this plan.
Reimbursement level <i>Prescription drugs</i>	80% after the deductible

<i>Drug substitution limit</i>	Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.
<i>Hospital expenses in your province</i>	100% without the deductible Semi-private room
<i>Convalescent hospital</i>	100% without the deductible \$20 per day up to 120 days for treatment of an illness due to the same or related causes
<i>Expenses out of your province</i>	Emergency – 100% after the deductible Referral – 80% after the deductible
<i>Emergency Travel Assistance</i>	Included
<i>Medical services and equipment</i>	80% after the deductible
<i>Gender affirmation procedures</i>	80% after the deductible Lifetime maximum – \$10,000 per person
<i>Paramedical services</i>	80% after the deductible
<i>Physiotherapists, Chiropractors, Athletic therapists</i>	\$2,000 per person per benefit year combined
<i>Psychologists, Psychotherapists</i>	\$500 per person per benefit year combined

Vision care <i>Contact lenses, eyeglasses, laser eye correction surgery or contact lenses for the treatment of specific medical conditions</i>	80% after the deductible \$250 combined in any 12 month period for a person under age 18 or in any 24 month period for any other person
Lifetime maximum benefit	Under Extended Health Care, the lifetime maximum amount we will pay for any person is \$90,000. The lifetime maximum does not apply to <i>Hospital expenses in your province.</i>
Termination	When you retire or reach age 71, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information.</i>

Dental Care

Benefit year	January 1 to December 31
Deductible	Individual – \$40 per benefit year Family – \$40 per benefit year
Fee Guide	2025 Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received Effective January 1, 2026 – 2026 Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received Effective January 1, 2027 – 2027 Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received Effective January 1, 2028 – 2028 Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that specialty, then the fee guide approved by the provincial Dental Association for that specialist will be used
Reimbursement level	
<i>Preventive procedures</i>	100% after the deductible
<i>Basic procedures</i>	100% after the deductible
<i>Major procedures</i>	50% after the deductible
<i>Orthodontic procedures</i>	50% without the deductible

Maximum benefit Benefit year maximum	\$2,075 per person <i>Effective January 1, 2026</i> – \$2125 <i>Effective January 1, 2027</i> –\$2175 <i>Effective January 1, 2028</i> –\$2225 Orthodontic procedures are not included in the benefit year maximum. A separate lifetime maximum applies If your coverage starts in the second half of a benefit year, the maximum amount for that benefit year will be reduced by 50%
Lifetime maximum	Orthodontic procedures – \$750 per person
Termination	The last day of the month in which you retire or reaches age 71, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i>.

Short-Term Disability

Maximum amount	70% of your weekly basic earnings, rounded to the next higher \$1, up to a maximum of \$860 <i>Effective January 1, 2026</i> – 70% of your weekly basic earnings, rounded to the next higher \$1, up to a maximum of \$870 <i>Effective January 1, 2027</i> –70% of your weekly basic earnings, rounded to the next higher \$1, up to a maximum of \$880 <i>Effective January 1, 2028</i> – 70% of your weekly basic earnings, rounded to the next higher \$1, up to a maximum of \$890 The maximum amount may be reduced by income provided from other sources as described in the <i>Short-Term Disability</i> section
Elimination period	Accident – none Illness – 3 days of uninterrupted total disability In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized

Maximum benefit period	If you are not eligible for Employment Insurance sickness benefits – 26 weeks If you are eligible for Employment Insurance sickness benefits - 41 weeks The period which must be completed before disability benefits become payable is the elimination period
Termination	When you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

Life

Employee Basic Life

Amount	\$55,000 <i>Effective January 1, 2026</i> – \$56,000 <i>Effective January 1, 2027</i> – \$57,000 <i>Effective January 1, 2028</i> – \$58,000
Termination	When you retire. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

Employee Optional Life

Amount	You can choose coverage in units of \$25,000 Maximum – \$250,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

Spouse Optional Life

Amount	You can choose coverage in units of \$25,000 Maximum – \$250,000
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Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire or reach age 70, or when your spouse reaches age 70 whichever is earlier. Coverage may also end on an earlier date, as specified in General Information.

Occupational Accidental Death

Amount	Equal to Employee Basic Life coverage
Termination	When you retire. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

General Information

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

About this booklet

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

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

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

Eligibility

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

- you are a permanent employee.
- you are actively working for your employer at least 40 hours a week.
- you have completed the waiting period.

The waiting period for your group plan is 60 calendar days.

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

rehabilitation program.

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 3 years, is an eligible dependent. There is no minimum cohabitation period if a child is born out of your relationship. You can only cover one spouse at a time.

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

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 as long as the child is entirely dependent on you for financial support.

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

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

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

Enrolment

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

to your employer. For a dependent to receive coverage, you must request dependent coverage.

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

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

When coverage begins

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

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

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

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

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

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

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

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

Accessing your records

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

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

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

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

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

following sources:

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

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

- the date your employment ends for any reason other than retirement on pension.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

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

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

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

- 24 months after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.

- the date the benefit provision under which the dependent is covered terminates.

The continuation of coverage does not apply to the spouse's Optional Life.

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

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

Proof of disability

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

Coordination of benefits

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

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

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

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

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

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

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

- the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

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

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

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

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

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

Medical examination We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or

refuse to have this examination, we will not pay any benefit.

Recovering overpayments

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

Assignments

For Life benefits, no rights or interests can be assigned.

For all other benefits, we reserve the right to refuse assignments.

Definitions

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

Accident

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

Appropriate treatment

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

Basic earnings

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

Doctor

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

Illness

An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Retirement date

If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

We, our and us

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

Extended Health Care (Medicare Supplement)

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	In this section, <i>you</i> means the employee and all dependents covered for Extended Health Care benefits. Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs (see <i>Prior authorization program</i> for details). <i>Medically necessary</i> means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards. To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits. <i>Reference to Doctor may also include a nurse practitioner</i> – 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 doctor. For drugs, refer to <i>Other health professionals allowed to prescribe drugs</i>. An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.
Benefit year	The benefit year is indicated in the Benefit Summary section.
Deductible	The deductible is the portion of claims that you are responsible for paying.

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

Lifetime maximum The maximum amount we will pay under Extended Health Care in a person's lifetime is specified in the Benefit Summary section.

Prescription drugs Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*. The reimbursement level is indicated in the Benefit Summary section.

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility.
- vaccines.
- drugs for the treatment of sexual dysfunction, up to a maximum of \$1,000 per person in a benefit year.
- intrauterine devices (IUDs) and diaphragms.
- varicose vein injections.

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

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

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

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

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

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

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

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.

- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

Prior authorization program

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

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

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

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

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

Reference Drug Program

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a therapeutic category).
- determine the most cost-effective drug within a therapeutic category (the Reference Drug), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular therapeutic category to the eligible cost of the Reference Drug (the Reference Drug Limit).
- apply the Reference Drug Limit to select province(s), excluding Québec. The selected province(s) may vary with each therapeutic category.

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.
- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

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

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

**Hospital expenses in
your province**

We will cover costs for hospital care in the province where you live. The reimbursement level is indicated in the Benefit Summary section.

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

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

The reimbursement level is indicated in the Benefit Summary section.

The maximum amount payable, for treatment of an illness due to the same or related causes, is the difference between the cost of the ward and the semi-private room, up to the limit specified in the Benefit Summary section.

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

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

**Expenses out of
your province**

We will cover emergency services while you are outside the province where you live. We will also cover referred services. The reimbursement level is indicated in the Benefit Summary section.

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

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

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

Emergency services

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

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Sun Life's ETA provider 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 Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

***Emergency services
excluded from
coverage***

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Sun Life's ETA provider, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

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

All referred services must be:

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

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

Medical services and equipment

We will cover the cost for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order). The reimbursement level is indicated in the Benefit Summary section.

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:

-
- laboratory tests.
 - ultrasounds.
 - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of \$1,000 per person per benefit year.
 - dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
 - services of an ophthalmologist or licensed optometrist, up to a maximum of \$25 per person over 2 benefit years.
 - contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
 - wigs following chemotherapy. Wigs do not require a doctor's order.
 - medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
 - casts, splints, trusses, braces or crutches.
 - breast prostheses required as a result of surgery, up to a maximum of \$200 per person in a benefit year.
 - surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.

- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings with a compression value of less than 20mmHg, up to a maximum of \$50 per person in a benefit year.
- pressure gradient hose, up to a maximum of \$200 per person per pair and limited to 4 pairs in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, to a maximum of one pair per person in a benefit year.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, to a maximum of one pair per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$500 over a period of 5 benefit years for a person under age 18 or \$300 over a period of 5 benefit years for any other person. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- insulin pumps.
- Continuous Glucose Monitor (CGM), including receivers, transmitters, and sensors, for persons diagnosed with Type 1 or Type 2 diabetes requiring insulin use. You must provide us with a doctor's note confirming the diagnosis.
- colostomy supplies.

Gender affirmation procedures

We will cover the costs for the following gender affirmation procedures, up to the lifetime maximum indicated in the Benefit Summary section, provided you meet the *Eligibility requirements* set out below.

Eligible procedures:

- breast augmentation/augmentation mammoplasty.
- thyroid chondroplasty.
- laryngoplasty.
- permanent hair removal (laser or electrolysis) for pre-surgical areas.
- hysterectomy.
- vaginectomy.
- salpingo-oophorectomy.
- chest contouring/chest masculinization, other than liposuction/lipofilling.
- implantation of penile and/or testicular prostheses.

We reserve 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

- You must be under the care of a doctor for gender affirming care.
- You must be at least 18 years old and must have been diagnosed with gender dysphoria by a doctor.
- Prior approval is required. You and your doctor must complete the *Gender Affirmation application form*, and submit it to us.
- All procedures must be considered medically necessary by your

doctor.

- All procedures must be performed in Canada.
- Only expenses incurred after your effective date for coverage under this benefit provision, and while this benefit provision is in force, will be eligible for reimbursement.

Before incurring an expense, you must call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212 to obtain the *Gender Affirmation application form*. We will assess all procedures based on the terms of this plan. We reserve the right to request details of procedures performed.

You may incur other expenses, such as drugs or paramedical services, related to gender affirming care. To determine if these other expenses are eligible under this plan, and any applicable benefit maximum, please refer to the *Prescription drugs*, *Paramedical services* or other applicable provisions of this Extended Health Care benefit.

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

- procedures payable or available under the medicare plan in your place of residence, regardless of whether you have applied to, or been accepted into, the gender affirmation program.
- travel or accommodations expenses.
- reversal of gender affirmation procedures.
- sperm preservation or cryopreservation of fertilized embryos.
- procedures related to fertility problems caused by gender affirming treatment and/or surgical care.

Paramedical services

We will cover the costs for all paramedical specialists listed below. The reimbursement level and the combined maximum amount we will pay are indicated in the Benefit Summary section.

- licensed physiotherapists.

- licensed chiropractors, including x-ray examinations.
- licensed athletic therapists, or athletic therapists who are active members of the Canadian Athletic Therapists Association (CATA) or of a provincial association approved by Sun Life.

We will cover the costs for all paramedical specialists listed below. The reimbursement level and the combined maximum amount we will pay are indicated in the Benefit Summary section.

- licensed psychologists.
- licensed psychotherapists, or psychotherapists who are active members of a provincial association approved by Sun Life.

Vision care

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

We will also cover the costs of contact lenses prescribed for the treatment of severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, if visual acuity in the better eye cannot be improved to at least 20/40 with eyeglasses.

The reimbursement level and the combined maximum amount payable are indicated in the Benefit Summary section.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.

Payments after coverage ends

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

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and

- while this provision is in force.

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

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

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

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

**Integration with
government
programs**

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

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

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

**When and how to
make a claim**

To make a claim, complete the claim form that is available from your employer or on our website at www.mysunlife.ca.

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

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

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

Emergency Travel Assistance

Insurer

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

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, Sun Life's Emergency Travel Assistance (ETA) provider can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Sun Life's ETA provider. If contact with Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Sun Life's ETA provider may arrange for:

On the spot medical assistance

Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities.

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

Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel.

Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Sun Life's ETA provider may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation.

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live:

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

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

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

Travel expenses of family members

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

- you are travelling alone, or

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

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

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

**Liability of Sun Life
or Sun Life's ETA
provider**

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

Dental Care

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	In this section, <i>you</i> means the employee and all dependents covered for Dental Care benefits. Dental Care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan. For each dental procedure, we will only cover reasonable charges. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. When a fee guide is not published for a given year, the term <i>fee guide</i> may also mean an adjusted fee guide established by Sun Life. When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure. If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service. An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.
Benefit year	The benefit year is indicated in the Benefit Summary section.

Deductible	The deductible is the portion of claims that you are responsible for paying.
Benefit year maximum	The maximum amount we will pay per person per benefit year is specified in the Benefit Summary section. Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.
Lifetime maximum	The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is specified in the Benefit Summary section.
Predetermination	We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$400. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.
Preventive dental procedures	Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health. The reimbursement level is indicated in the Benefit Summary section.
Oral examinations	1 complete examination every 24 months. 1 recall examination every 5 months, up to a maximum of 2 examinations per benefit year. Emergency or specific examinations.
X-rays	1 complete series of x-rays or 1 panorex every 24 months. 1 set of bitewing x-rays every 5 months, up to a maximum of 2 sets per benefit year. X-rays to diagnose a symptom or examine progress of a particular course of treatment.

<i>Other services</i>	Required consultations between two dentists. Required consultation with patient and treatment planning. Polishing (cleaning of teeth) and topical fluoride treatment once every 5 months, up to a maximum of 2 per benefit year. Emergency or palliative services. Diagnostic tests and laboratory examinations. Removal of impacted teeth. Provision of space maintainers for missing primary teeth. Pit and fissure sealants.
Basic dental procedures	Your dental benefits include the following procedures used to treat basic dental problems. The reimbursement level is indicated in the Benefit Summary section.
<i>Fillings</i>	Amalgam, composite, acrylic or equivalent.
<i>Extraction of teeth</i>	Removal of teeth, except removal of impacted teeth (<i>Preventive dental procedures</i>) and alveolectomy at time of tooth extraction.
<i>Basic restorations</i>	Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.
<i>Endodontics</i>	Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.
<i>Periodontics</i>	Treatment of disease of the gum and other supporting tissue.
<i>Other services</i>	Surgical excision of tumours, cysts or neoplasms. Surgical incision and drainage of abscess. Necessary treatment for relief of dental pain.

	Medications provided by injection in the dentist's office.
Oral surgery	Surgery, other than the removal of impacted teeth (<i>Preventive dental procedures</i>).
Anaesthesia	Anaesthesia in conjunction with a dental procedure covered under this plan.
Major dental procedures	Your dental benefits include the following procedures used to treat major dental problems. The reimbursement level is indicated in the Benefit Summary section.
Major restorations	Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (<i>Basic dental procedures</i>).
Repair	Repair of bridges or dentures.
Rebase or reline	Rebase or reline of an existing partial or complete denture.
Prosthodontics	Construction and insertion of bridges or standard dentures. Coverage is limited to teeth extracted while you are covered under this plan. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless: ■ it is needed to replace a bridge or standard denture which cannot be made serviceable However, if the existing appliance can be made serviceable, but a replacement bridge or standard denture is required following extraction of additional teeth while a person is covered under this provision, only the expense for the portion required to replace the tooth or the teeth extracted is considered an eligible expense. ■ it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition. ■ it is needed to replace a transitional denture which was inserted

shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Orthodontic procedures

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

The reimbursement level is indicated in the Benefit Summary section.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

Payments after coverage ends

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

Reimbursement under this plan is limited to the balance of eligible expenses incurred and not reimbursed under the Extended Health Care benefit as a result of the application of the deductible or the reimbursement level. Only expenses eligible under the Dental Care benefit are considered for reimbursement.

What is not covered

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

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

We will not pay for:

- procedures performed primarily to improve appearance other than orthodontic procedures.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- implants and transplants, and repositioning of the jaw.
- experimental treatments.
- oral hygiene instructions, dietary planning and plaque control.
- treatment not yet approved by the Canadian Dental Association or which is clearly experimental in nature.
- any treatment received from a dental or medical department maintained by CN, a labour Union, a mutual benefit association or a similar type of group.

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

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.
- participation in a criminal offence.
- an injury sustained while working for pay or profit.

**When and how to
make a claim**

To make a claim, complete the claim form that is available from your employer or on our website at www.mysunlife.ca. The dentist will have to complete a section of the form.

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

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

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

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

Short-Term Disability (Weekly Indemnity)

Insurer

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

**General description
of the coverage**

Short-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you present proof of claim acceptable to Sun Life that:

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

For the purposes of your Short-Term Disability coverage, you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation.

Your benefits will be based on your coverage on the date you became totally disabled. Benefits are paid at the end of each week for which you are entitled to payments.

**When disability
payments begin**

If you become totally disabled because of an **accident** or **illness**, you will be eligible for Short-Term Disability payments on the later of the following:

- after you have been totally disabled for the number of days indicated in the Benefit Summary (elimination period), or
- the first day you consult a doctor.

In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized.

If you are totally disabled for part of any week, we will pay 1/7 of the weekly benefit for each day you are totally disabled.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for

benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for the elimination period indicated in the Benefit Summary, and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer. In the case of an accident, you must be totally disabled on the date you are recalled or scheduled to return to full-time work.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous total disability if it occurs within 4 weeks of the end of your previous disability. You must be covered when the total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum benefit period.

What we will pay

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

Step 1: We take the maximum amount indicated in the Benefit Summary section.

Step 2:

(a) **During the entire period of total disability**, we subtract any income provided to you:

- under a motor vehicle insurance plan which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.
- under a group plan which provides income replacement benefits as a result of an accident or an illness, including a multiple-employer group plan.

- as part of a salary continuance received from your employer during your disability.
 - under Employment Insurance.
 - under the Québec Parental Insurance Plan.
- (b) **After the first 17 weeks of total disability**, when the maximum benefit period is more than 17 weeks, we also subtract any income provided to you:
- in connection with the same or a subsequent disability under any government-sponsored plan*, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases that occur after benefits begin.
 - under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
 - under any coverage resulting from your membership in an association of any kind.

The result from Step 2 is the amount you would normally receive as a Short-Term Disability payment. However, if the amount calculated under Step 2, plus:

- **during the first 17 weeks of total disability** – the sources of income listed in (a) above, exceeds 85% of your pre-disability basic earnings (after income tax, if the benefit is non-taxable),
- **after the first 17 weeks of total disability** – the sources of income listed in (a) and (b) above, exceeds 85% of your pre-disability basic earnings (after income tax, if the benefit is non-taxable),

your Short-Term Disability payment is reduced by the excess.

*If you first become entitled to Québec Pension Plan (QPP) disability benefits:

- before age 60, we will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.
- on or after age 60, we will deduct the amount provided in your NOE and an additional amount. The additional amount represents a portion of the retirement amount, payable or available following an approved QPP disability application, and is comparable to the variable portion of QPP disability benefits for persons under age 60. These deducted amounts will not change for the duration of your disability claim.

If you are entitled to any of the amounts described above, we will estimate the amount of such benefits or income and deduct the estimated amount from your weekly disability benefit when you:

- fail to apply for the benefits or income, or exhaust all levels of appeal.
- fail to make a new application, following a declined application or appeal.
- refuse to receive or accept some or all of the benefits or income, or choose to cancel them.
- fail to provide us with information related to:
 - the status of an application, appeal or reapplication,
 - the benefit or income amount, even if it has been refused or cancelled,

within 30 days of our request for information.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.

We will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

**Maternity / parental
leave of absence**

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

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

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

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

Short-Term Disability benefits will be payable for health-related portions of the leave, after you have been disabled for the elimination period indicated in the Benefit Summary provided your coverage has been continued.

This plan constitutes a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations for the health-related portion of the maternity or parental leave, up to 16 weeks. Sun Life will pay the difference, if any, between:

- the Short-Term Disability benefit payment, and
- any income you are eligible to receive under Employment Insurance maternity or parental leave benefits.

**Rehabilitation
program**

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

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

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

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

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled.

**If you recover
damages from
another person**

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

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

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

When payments end

Your Short-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the end of a maximum benefit period indicated in the Benefit Summary, reduced by the elimination period.
- the date you retire on pension.
- the date you die.

Payments after coverage ends

If the Short-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence*. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
- you are absent from Canada longer than 4 weeks, unless Sun Life agrees in writing in advance to pay benefits during such period or unless the absence is for the purpose of obtaining medical treatment and would be permitted under the Employment Insurance regulations.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay if benefits are payable to you under any Workers' Compensation Act or similar legislation.

We will not pay for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

**When and how to
make a claim**

To make a claim, claim forms that are available from Sun Life must be completed. You, the attending doctor and your employer will all have to complete claim forms.

In order for you to receive benefits, we must receive these forms no later than 30 days after your total disability begins.

We will assess the claim and send you or your employer a letter outlining our decision.

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

Life Coverage

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.
What we will pay	The amount of coverage is indicated in the Benefit Summary section.
Who we will pay	If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount 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 desire to designate a minor as your 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 estate (or your spouse's estate in the case of Optional Life coverage for your spouse) as beneficiary and provide the executor(s) with directions in your (or your spouse's) will as to the entitlement of the minor. You are encouraged to consult a legal advisor.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide,

**Coverage during
total disability**

regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

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

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

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

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

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

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

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

Converting Life coverage

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

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

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

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

When and how to make a claim

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

Occupational Accidental Death

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada.</i>
General description of the coverage	Occupational Accidental Death coverage provides a benefit if you die due to an accident which occurs while you are covered for this benefit and performing the duties of your employment for your employer. Your death must occur within 365 days of the accident. Any death benefit paid under this coverage is in addition to the Life coverage.
What we will pay	The amount of coverage is indicated in the Benefit Summary section.
Limit on benefit amounts	If more than one person covered by the group contract is eligible for benefits resulting from the same accident, Sun Life will pay up to a maximum of \$3,000,000 for all claims related to the accident. If the total amount of benefits payable for the accident is more than \$3,000,000, then we will pay for each person a percentage of the \$3,000,000 that is equal to the percentage the person would have received of the total payable.
Repatriation benefit	If you die as a direct result of an accident 100 kilometres or more from home, we will pay up to \$10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan. We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.
Spouse occupational training benefit	If you die as a direct result of an accident, we will pay up to \$5,000 to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the expenses and all expenses must be incurred within 3 years of the date of the accident. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the training program will be based on the likelihood that it will be successful.

Child education benefit

If you die as a direct result of an accident, we will pay for a dependent child's tuition fees in a post-secondary school. We will pay the child 5% of the amount of coverage up to \$5,000, each year up to a maximum of 4 years. The child must enrol as a full-time student within one year of your death.

We will only pay for the usual and reasonable tuition expenses. This does not include ordinary living expenses such as room, board, travelling or clothing. This also does not include education expenses incurred prior to your death.

Family transportation benefit

If you suffer a loss as a direct result of an accident and are hospitalized at least 150 kilometres from home, we will pay up to \$5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister.

We will only pay for the usual and reasonable travel expenses. We will pay for car travel at a rate of \$0.20 per kilometre. Transportation must be by the most direct route to and from the hospital. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

What is not covered

We will not pay for losses that are the result of:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.

- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- flying in an aircraft, descending from an aircraft or being exposed to any hazard related to an aircraft, while:
 - receiving flying lessons.
 - performing any duties in connection with the aircraft.
 - being flown for a parachute jump.
 - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence.

When and how to make a claim

The claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

Basic Accidental Death and Dismemberment

Insurer

This benefit is insured by AIG Insurance Company of Canada

DECLARATIONS	
INSURER	AIG Insurance Company of Canada (the Company)
POLICY NUMBER	GPA 9426795
POLICYHOLDER	The Toronto Terminals Railway Co. Ltd
ADDRESS OF THE POLICYHOLDER	1400B - 50 Bay Street TORONTO ON M5J 3A5
ISSUE DATE	11.16.2023
EFFECTIVE DATE	12:01 a.m. local time at the Policyholder's address on the 1 st day of November 2023.
EXPIRATION DATE	12:01 a.m. local time at the Policyholder's address on the 1 st day of January 2025.
PLAN	BASIC ACCIDENTAL DEATH AND DISMEMBERMENT
ELIGIBLE CLASSES OF INSURED EMPLOYEES	Employees: • Canadian domiciled individuals; • employed by the Policyholder or an affiliate thereof on a permanent, full-time basis; and • who are a member of one of the following Classes of Eligible Employees: Class I: All unionized Employees of Deltaport Class II: All unionized Employees of Unifor agreement 5.32, IBEW agreement 7.08 and IBEW

	agreement 11.6
TERMINATION OF COVERAGE	Employee: The earlier of retirement or age [70]
AGGREGATE LIMIT PER ACCIDENT	Nil

PREMIUM RATES AND PRINCIPAL SUMS

Class of Insured Persons	Principal Sum		Type of Coverage
Class I		Flat \$100,000	24 hour
Class II		Flat \$100,000	Occupational Only
REDUCTION SCHEDULE	The Principal Sum payable under this Policy will reduce by 50% at age 65 (Applies to Class I Only)		

Schedule of Benefits

These benefits of the policy only apply if selected by the Policyholder (indicated by “Yes” in the Covered Benefit column) and the appropriate premium paid.

Benefit	Covered Benefit	Maximum Amount Payable per Insured Employee per Accident (CAD\$)
ACCIDENTAL DEATH AND DISMEMBERMENT	YES	Percent of Principal Sum per Table of Losses
DISAPPEARANCE	YES	Principal Sum
REHABILITATION	YES	Up to \$15,000
HOME ALTERATION AND VEHICLE MODIFICATION	YES	Up to \$15,000
WORKPLACE MODIFICATION AND ACCOMMODATION	YES	Up to \$5,000

Contract No. GPA 9426795 Basic Accidental Death and Dismemberment

Benefit	Covered Benefit	Maximum Amount Payable per Insured Employee per Accident (CAD\$)
PSYCHOLOGICAL THERAPY	YES	Up to \$5,000
IN-HOSPITAL BENEFIT	YES	Up to \$2,500/month
FAMILY TRANSPORTATION	YES	Up to \$15,000
REPATRIATION BENEFIT	YES	Up to \$15,000
IDENTIFICATION BENEFIT	YES	Up to \$5,000
DAY CARE	YES	Up to \$5,000
DEPENDENT CHILD EDUCATIONAL BENEFIT	YES	Up to \$5,000
SPOUSAL EDUCATIONAL BENEFIT	YES	Up to \$15,000
FUNERAL EXPENSE	YES	Up to \$5,000
BEREAVEMENT BENEFIT	YES	Up to \$1,000
SEAT BELT AND AIR BAG BENEFIT	YES	Additional 10% of Principal Sum to a maximum of \$50,000
DISABILITY FITNESS BENEFIT	NO	
PARENTAL CARE BENEFIT	NO	
CARJACKING BENEFIT	NO	
PERMANENT AND TOTAL DISABILITY	NO	
CRIMINAL ASSAULT BENEFIT	NO	
COSMETIC DISFIGUREMENT	NO	
COMA BENEFIT	NO	
SURGICAL REATTACHMENT	NO	50% of the Loss listed on the Table of Losses
WAR RISK COVERAGE	NO	

Benefit	Covered Benefit	Maximum Amount Payable per Insured Employee per Accident (CAD\$)
SERIOUS ILLNESS	NO	

Section 1 : Definitions

There are words and expressions used in this group policy which have a specific meaning, and sometimes those meanings are unique to this policy. These words are shown below and each time one of them is used in the policy and Policy Schedule (and any endorsements or memoranda attached to the Policy Schedule), it is with Initial Capital Letters. Plural forms of the words defined have the same meaning as the singular form.

Please read each section of the policy for additional definitions applicable to those sections and subsections.

Activities of Daily Living: The following six activities:

1. Maintaining continence: ability to control urination and bowel movements, including the use of ostomy supplies or other devices such as catheters if required;
2. Transferring: ability to move in and out of a bed, between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing including braces, artificial limbs or other surgical appliances;
4. Toileting: use of a lavatory including getting to and from and getting on and off, to manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Eating: ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower or washing satisfactorily by other means.

Aircraft: A vehicle used for aerial navigation which has a valid certificate of airworthiness and is being flown by a pilot with a valid license to operate the Aircraft.

Annual Earnings: The Insured Employee's annual salary from employment with the Policyholder or the Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

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

Carjacking: Taking unlawful possession of a Private Passenger Type Automobile by means of force or threats against the Insured Employee(s) then rightfully occupying such Private Passenger Type Automobile.

Charter Flight: Air travel that is chartered for a specific trip, or part of a trip, and the air travel is not part of an airline's regularly scheduled flight.

Company: AIG Insurance Company of Canada.

Declarations: The Declarations relating to this policy as set out in the Policy Schedule.

Dependent Child(ren): A person who is either the natural child, adopted child or step-child of the Insured Employee, or an infant to which the Insured Employee is "*in loco parentis*", and who is:

- (a) under 23 years of age, unmarried and dependent upon the Insured Employee for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of Loss;
- (b) under 26 years of age and unmarried and in attendance at an Institution of Higher Learning and dependent upon the Insured Employee for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of Loss; or
- (c) by reason of mental or physical infirmity, incapable of self-sustaining employment and who is considered a dependent child of the Insured Employee within the terms of the Income Tax Act (Canada).

Dependent Parent: The Insured Employee's parents, parents-in-law, grandparents, grandparents-in-law, great-grandparents or great-grandparents-in-law that are dependent upon the Insured Employee for support, maintenance and care.

Effective Date: The date stipulated as the date stated within the Policy Schedule Declarations as the date from which coverage begins under this policy.

Employer: The Policyholder or an affiliate or subsidiary thereof which employs the Eligible Classes of Insured Employees set out within the Policy Schedule Declarations.

Hospital: An establishment which:

- (a) holds a licence as a hospital (if licencing is required in the jurisdiction);
- (b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- (c) provides 24 hour a day nursing service by registered or graduate nurses;
- (d) has a staff of one or more licenced Physicians available at all times;
- (e) provides organized facilities for diagnosis, and major medical surgical facilities;
- (f) is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and
- (g) is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate Family: A person who is related to the Insured Employee in any of the following ways: a spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (including legally adopted or stepchild).

Injury or Injuries: Bodily injury which is sustained by an Insured Employee as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while the Insured Employee's insurance under this policy is in force.

Institution of Higher Learning: A school that provides a post-secondary program of education which includes, but is not limited to, any university, private post-secondary college or trade school, and any College of General and Vocational Education/ Collège d'enseignement général et professionnel (CÉGEP).

Insured Employee: An individual who belongs to an Eligible Class of Insured Employees specified in the Policy Schedule Declarations provided such individual's name is on file with the Policyholder as being insured under this policy.

Leased Aircraft: An aircraft owned by a person other than the Insured Employee's Employer that is used by the Policyholder or such Employer under the terms of a fixed agreement for a specified duration of time.

Loss when used with reference to:

- (a) **Quadriplegia, Paraplegia, and Hemiplegia** means the complete and irreversible paralysis of such limbs;
- (b) **Hand or Foot** means the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- (c) **Arm or Leg** means the complete and irrecoverable severance through or above the elbow or knee joint;
- (d) **Thumb and Index Finger** means the complete and irrecoverable severance through or above the first phalange;
- (e) **Fingers** means the complete and irrecoverable severance through or above the first phalange of all four Fingers of one Hand;
- (f) **Toes** means the complete and irrecoverable severance of both phalanges of all the toes of one foot;
- (g) **The Entire Sight of One Eye** means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye;
- (h) **The Entire Sight of Both Eyes** means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing;

- (i) **Hearing in One Ear** means the diagnosis of permanent loss of Hearing in one Ear, with an auditory threshold of more than 90 decibels. A Physician certified in otolaryngology must confirm the diagnosis in writing;
- (j) **Hearing** means the diagnosis of permanent loss of Hearing in both ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in otolaryngology must confirm the diagnosis in writing;
- (k) **Speech** means complete and irrecoverable loss of the ability to utter intelligible sounds; and
- (l) **Loss of Use** means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

Loss when used herein may also include **Loss of Life**.

Owned Aircraft: An aircraft to which the Policyholder or the Employer (or a related company, subsidiary, affiliate, parent company, principal, officer or employee or family member of an officer or employee of the Policyholder, the Employer or such entity) holds legal or equitable title such that the Policyholder, Employer or such entity or person can use, alter or sell the aircraft as they wish.

Permanent and Total Disability: Injury which prevents an Insured Employee from performing at least two of the six Activities of Daily Living, without assistance from another person and the Insured Employee has been determined on evidence satisfactory to the Company, to be and remain, as of 12 months after the date of the Injury, incapable of performing at least two of the six Activities of Daily Living without assistance from another for the remainder of his or her life. The disability must be determined to be total, permanent, and irreversible and certified to be such by a Physician acceptable to the Company. The Insured Employee's inability to actually obtain employment is not a criteria to qualify for the Permanent and Total Disability benefit.

Physician: A medical doctor, other than the Insured Employee or the Insured Employee's Immediate Family, who is licenced to administer medical treatment and prescribe drugs in the place where he or she provides medical services. The following are not considered to be Physicians: naturopath, herbalist and homeopath.

Policy Schedule: The Group Personal Accident Policy Schedule listing policy Declarations, Premium Rates, Principal Sums and the Schedule of Benefits, which should be read with this policy.

Principal Sum: That amount specified in the Policy Schedule Declarations as the Principal Sum for an Insured Employee based on the Class of Eligible Employee's to which an Insured Employee belongs.

Private Passenger Type Automobile: Any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

Spouse: A person who is either:

- (a) legally married to the Insured Employee, or if there is no such person;
- (b) a person who, although not legally married to the Insured Employee, is cohabitating with the Insured Employee and is publicly represented as the Insured Employee's domestic partner in the community in which they reside.

Supplemental Restraint System: An air bag which inflates for added protection to the head and chest areas.

Table of Losses: The table set out in Section 5.1 of this policy.

Section 2 : Term of Coverage

TERM OF POLICY

This policy commences on the Effective Date and continues until the Expiration Date stated within the Policy Schedule Declarations and, unless otherwise terminated or cancelled in accordance with the terms of this policy, it shall continue in effect until the last day of the period for which premium has been paid.

TERMINATION OF POLICY

- (a) The Policyholder may terminate this policy by giving at least 31 days advance written notice to the Company which termination shall be effective at 12:01 am at the Policyholder's address on the date set out in such notice. In the event that this policy is terminated by the Policyholder, the Company shall refund the amount of unearned premium, if any, on a pro rata basis, subject to a 10% reduction.
- (b) The Company may terminate this policy effective at any time by providing at least 31 days advance written notice of termination to the Policyholder which termination shall be effective at 12:01 am at the Policyholder's address on the date set out in such notice. A notice of termination given to the Policyholder by the Company shall be binding on each Insured Employee as if such notice had been sent directly to each Insured Employee. A pro rata premium shall be paid by the Policyholder for any fraction of a month for which this policy is in effect. The Company shall refund the amount of unearned premium, if any, on a pro rata basis.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE COVERAGE

The insurance of an individual shall take effect on the later of:

- (a) the date such person satisfies the definition of Insured Employee;
- (b) the date requested by the Policyholder; and
- (c) the Effective Date of this policy.

If a person enters an Eligible Class of Employee as specified in the Policy Schedule Declarations, or changes from one such class to another, any consequential change in coverage hereunder shall take effect on the effective date of the change, except that if the

person changes from one Eligible Class of Employee to another and is absent from active full-time work on the effective date of such change for employment purposes, any consequential change in coverage hereunder shall only become effective upon the date the person returns to active full-time work.

TERMINATION OF INDIVIDUAL INSURANCE COVERAGE

The insurance of an Insured Employee shall immediately end on the earliest of:

- (a) the date he or she no longer satisfies the definition of Insured Employee; or
- (b) the date the Termination of Coverage is met as set out in the Policy Schedule; or
- (c) the date this policy terminates.

Section 3 : Premium

- (a) If the Premium Frequency stated in the Policy Schedule Declarations is monthly in arrears, all required premium shall be paid by the Policyholder in arrears and by no later than the 15th day of each month commencing with the month following the month in which the Effective Date occurs.
- (b) If the Premium Frequency stated in the Policy Schedule Declarations is annually, all required premium shall be paid by the Policyholder on or before the 60th day after the Effective Date. In the event of a change in coverage any additional premium must be paid on or before the 60th day after the effective date of such change.
- (c) If all the required premium is not paid during the applicable period set out in Section 3(b) this policy and the coverage hereunder does not come into effect. If all the premium is not paid as required under Section 3(a) this policy terminates at the end of the period permitted under such section for the payment of premium and the Policyholder shall owe and shall pay to the Company all the premiums accruing up to the date of termination of this policy.
- (d) The Company may, by notifying the Policyholder, alter the rate stipulated in the Policy Schedule Declarations at which premiums shall be computed. The Company shall provide the Policyholder with at least 60 days advance written notice of any such change in rates.

Section 4 : Policyholder's Obligations

INFORMATION TO BE PROVIDED TO INSURED EMPLOYEES

The Policyholder shall inform Insured Employees regarding the coverage which is provided under this policy and regarding the limitations of and exclusions from such coverage. This shall be done in a document, whether in written or electronic form, which shall be provided by the Policyholder to each Insured Employee. In the event of an amendment to the terms of this policy the Policyholder shall also deliver to Insured Employees an additional or amended document

pertaining to such change. The Insured Employee and any claimant may request a copy of the Group Policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

INFORMATION TO BE FURNISHED ABOUT INSURED EMPLOYEES

The Policyholder must provide the Company, upon request, with all the information the Company requires to properly administer the coverage provided under this policy including but not limited to:

- (a) an accurate list of the names, home and work addresses of Insured Employees and the information required to determine an Insured Employee's Principal Sum, the amount of any benefit payable hereunder and the applicable premium for each Insured Employee; and
- (b) the names of any Insured Employees who have left the employment of the Employer and the date of their departure.

ACCESS TO RECORDS

On reasonable advance written notice, provided by the Company to the Policyholder, the Policyholder shall grant the Company access to salary records and other files which pertain to and which would allow the Company to verify eligibility, an Insured Employee's Principal Sum, the amount of any benefit payable hereunder and the premium to be paid hereunder.

OBLIGATION OF POLICYHOLDER TO ENSURE ACCURACY AND CONSISTENCY WITH COLLECTIVE AGREEMENT

The Policyholder is obliged to accurately determine if a person is eligible for coverage under this policy and to submit the applicable premium for each Insured Employee. The incorrect or erroneous submission of premium by the Policyholder does not have the effect of in any way altering the coverage otherwise available to any person under this policy nor does it have the effect of in any way affording coverage to any person under this policy if such person is not eligible. Further, the Policyholder shall ensure that if any collective agreement shall pertain or does pertain to the benefits afforded by this policy, that such collective agreement is consistent with and does not afford any lesser benefits or rights to Insured Employees than is provided hereunder.

Section 5 : Primary Benefits

These sections of the policy only apply if selected by the Policyholder and the appropriate premium paid.

Accidental Death and Dismemberment Benefit

The Company shall pay the amount specified in the Table of Losses, if an Insured Employee sustains a Loss stated therein resulting from Injury, provided that:

- (a) such Loss occurs within 365 days after the date of accident causing such Loss;
- (b) the amount of the benefit payable for any such Loss shall be the amount set out in the Table of Losses, for that specific Loss; and
- (c) if more than one Loss is sustained as the result of any accident, only one benefit shall be payable, the largest.

TABLE OF LOSSES		Percentage Principal Sum Payable
Loss		
Loss of Life		100%
Loss of Both Hands or Both Feet		100%
Loss of Entire Sight of Both Eyes		100%
Loss of One Hand and One Foot		100%
Loss of One Hand and the Entire Sight of One Eye		100%
Loss of One Foot and the Entire Sight of One Eye		100%
Brain Death		100%
Loss of One Arm or One Leg		80%
Loss of One Hand or One Foot		75%

TABLE OF LOSSES		Percentage Principal Sum Payable
Loss of The Entire Sight of One Eye		75%
Loss of Thumb and Index Finger of the Same Hand		33.3%
Loss of Speech and Hearing		100%
Loss of Speech or Hearing		75%
Loss of Hearing in One Ear		66.7%
Loss of Four Fingers of One Hand		33.3%
Loss of All Toes of One Foot		25%
Loss of Use		
Loss of Use of Both Arms or Both Hands		100%
Loss of Use of One Hand or One Foot		75%
Loss of Use of One Arm or One Leg		80%
Paralysis		
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the Principal Sum up to a maximum of \$1 million	
Paraplegia (total paralysis of both lower limbs)	Two times the Principal Sum up to a maximum of \$1 million	
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the Principal Sum up to a maximum of \$1 million	

Disappearance

If the body of an Insured Employee has not been found within one year, the Insured Employee will be deemed to have suffered Loss of Life only if their disappearance involved the forced landing, stranding, sinking or wrecking of a conveyance.

Rehabilitation Benefit

If an Insured Employee suffers Injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, the Company shall pay the reasonable and necessary expenses actually incurred for the occupational training of the Insured Employee, provided that:

- (a) such training is required because of such Injury and in order for the Insured Employee to be qualified to engage in an occupation in which they would not have been engaged except for having suffered such Injury;
- (b) the training expenses are incurred within three years from the date of the accident causing such Injury; and
- (c) no payment shall be made for ordinary living, travelling or clothing expenses.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Home Alteration and Vehicle Modification

If an Insured Employee suffers Injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses and which Loss results in and necessitates the use of a wheelchair in order for the Insured Employee to be ambulatory, the Company shall pay the reasonable and necessary expenses actually incurred for:

- (a) the one-time cost of alterations to the injured Insured Employee's residence to make the residence wheel-chair accessible and habitable; and
- (b) the lesser of:
 - (i) the one-time cost of modifications necessary to a motor vehicle, owned by the injured Insured Employee, to make the vehicle accessible or drivable for the Insured Employee; and
 - (ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

This benefit is payable only if:

- (a) home alterations are made on behalf of the Insured Employee and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
- (b) vehicle modifications are made on behalf of the Insured Employee and carried out by an experienced individual in such matters and modifications are approved by the provincial vehicle licencing authorities in the Insured Employee's province of residence.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Workplace Modification and Accommodation

If an Insured Employee suffers Injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses and which Loss results in and necessitates the use of special adaptive equipment and/or workplace modification in order to reasonably accommodate the Insured Employee's return to active full-time work with his or her Employer, the Company shall pay to the Insured Employee's Employer, upon the Insured Employee's return to active full-time work with the Employer, the reasonable and necessary expenses actually incurred by the Employer for such adaptive equipment and/or workplace modification provided:

- (a) the Employer agrees in writing with the Company to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of such Insured Employee;
- (b) the Employer acknowledges in writing to the Company that the performance of the essential duties of such Insured Employee's job may be altered; and

- (c) the proposed special adaptive equipment and/or workplace modification have been approved in advance of an expense being incurred by the Employer for such equipment or modification.

The Company shall be afforded the opportunity to examine the Insured Employee to evaluate the appropriateness of the proposed modifications.

This benefit is payable only once in connection with Injuries and Losses suffered by any one Insured Employee, regardless of the number of policies, providing coverage for a workplace modification and accommodation benefit, that may be issued by the Company to the Policyholder or the Employer.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Psychological Therapy

If an Insured Employee sustains Injury which results in a Loss payable under the Table of Losses other than Loss of Life, and subsequently as a result of such Injury and Loss, the Insured Employee requires, within two years from the date of such Injury, Psychological Therapy as prescribed by a Physician, the Company will pay the reasonable and customary expenses for Psychological Therapy.

“Reasonable and Customary” means the lesser of:

- (a) the usual charge made by Physicians or other health care providers for a given service or supply; or
- (b) the charge determined to be the prevailing charge made by Physicians or other health care providers for a given service or supply in the geographical area where it is furnished; or
- (c) the amount negotiated by the Company and the health care provider.

“Psychological Therapy” means treatment or counselling by a therapist or counsellor, who is licenced, registered, or certified to provide such treatment, whether such treatment is on an out-patient basis or provided while a patient at a medical facility licenced to provide such treatment.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

In-Hospital Benefit

If an Insured Employee suffers Injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Employee is, pursuant to the instructions of a Physician, confined to a Hospital for more than five consecutive overnight stays, the Company will pay:

- (a) for a period of confinement in Hospital of more than 30 consecutive overnight stays, 1% of the Insured Employee's Principal Sum; or

- (b) for a period of confinement of 30 consecutive overnight stays or less, 1/30 of the amount determined in accordance with Section 5.7(a) for each overnight stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first overnight stay of confinement in Hospital.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Benefits are not payable for more than a total of 12 months of confinement for any one accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three months, are considered one period of confinement to Hospital for the purposes of calculating this benefit.

Family Transportation

If an Insured Employee suffers Injury resulting in a Loss (other than Loss of Life) set out in the Table of Losses and if such Loss requires that the Insured Employee be confined to a Hospital located more than 100 kilometres from his or her permanent place of residence, the Company shall pay the reasonable and necessary expenses actually incurred for the transportation of one Immediate Family member to such Hospital. This benefit is only payable if:

- (a) confinement to Hospital occurs within 365 days of the accident causing Injury; and
- (b) reimbursement of expenses are limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such Immediate Family member.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Repatriation Benefit

If an Insured Employee suffers Injury causing Loss of Life and for which a benefit is paid or payable hereunder and:

- (a) such Loss of Life occurs more than 50 kilometres from his or her permanent city of residence; and
- (b) such Loss of Life occurs within 365 days of the date of the accident causing the Injury,

the Company shall pay the actual expenses incurred for preparing the deceased Insured Employee for burial or cremation and shipment of the body to the city of residence of the deceased Insured Employee.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Identification Benefit

If an Insured Employee suffers Injury causing Loss of Life for which a benefit is paid or payable hereunder and the Insured Employee's body requires identification, the Company will pay to one

Immediate Family member of the Insured Employee, the reasonable and necessary expenses actually incurred by such Immediate Family member for:

- (a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three consecutive nights); and
- (b) transportation by the most direct route to such location.

This benefit is payable by the Company only if the body of the Insured Employee is located not less than 150 kilometres from the said Immediate Family member's normal place of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the licence for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of \$0.40 per kilometre travelled.

This benefit is payable only once in connection with Injuries and Losses suffered by any one Insured Employee, regardless of the number of policies providing coverage for this benefit for such Insured Employee, that may be issued by the Company.

The Maximum Amount Payable per Insured Employee for this benefit is listed on the Policy Schedule.

Day Care Benefit

If an Insured Employee suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Employee, an amount equal to the lesser of the following:

- (a) the actual annual cost charged by a commercial and licenced day care centre; or
- (b) 5% of the Insured Employee's Principal Sum; or
- (c) the Maximum Amount Payable listed on the Policy Schedule per year.

This benefit is payable annually for a maximum of four consecutive payments per Dependent Child:

- (a) only for such Dependent Child who at the date of the Insured Employee's Loss of Life is under age 13;
- (b) provided such Dependent Child is enrolled in a commercial and licenced day care centre no later than 90 days following the Insured Employee's Loss of Life; and
- (c) provided that the Dependent Child continues his or her enrollment in a commercial and licenced day care centre.

Dependent Child Educational Benefit

If an Insured Employee suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Employee up to the lesser of the following amounts:

- (a) the Maximum Amount Payable listed on the Policy Schedule per school year; or
- (b) 5% of such Insured Employee's Principal Sum.

This benefit is payable annually up to a maximum of four consecutive payments per Dependent Child:

- (a) only for such Dependent Child who is, at the time of such Insured Employee's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the 12th grade level; and
- (b) only while such Dependent Child continues his or her continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who has incurred the actual tuition expenses.

Spousal Educational Benefit

If an Insured Employee suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Employee's Spouse the actual cost incurred for a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than 36 months after the Insured Employee's Loss of Life.

The Maximum Amount Payable for this benefit per Insured Employee is listed on the Policy Schedule.

Funeral Expense

If an Insured Employee suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the reasonable and usual expenses incurred with a mortician, crematory or a funeral home, for the services or supplies related to the burial or cremation. The Company shall also reimburse the usual expenses relative to the purchase of a cemetery plot, grave or mausoleum, including a plaque, tombstone or monument. This benefit is payable to the person who has incurred the actual expenses pertaining to the cremation, burial or funeral expenses of the Insured Employee.

The Maximum Amount Payable for this benefit per Insured Employee is listed on the Policy Schedule.

Bereavement Benefit

If an Insured Employee suffers Injury which results in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay the reasonable and necessary expenses actually incurred for grief counselling provided that:

- (a) the counselling is for the Spouse and/or Dependent Children;
- (b) such expenses are incurred within 365 days of the date of the Loss of Life; and
- (c) such grief counselling is provided by a therapist or counsellor who is licenced, registered or certified to provide such treatment and who is not a member of the Immediate Family of the Insured Employee.

The Company will pay the person who has incurred the actual expense.

The Maximum Amount Payable for this benefit is listed on the Policy Schedule.

Seat Belt and Air Bag Benefit

If an Insured Employee suffers Injury resulting in Loss of Life for which the Company has paid a benefit set out in the Table of Losses, the Company shall pay an additional amount equal to 10% of the Insured Employee's Principal Sum if Injury causing the Loss of Life results while he or she is a passenger or driver of a Private Passenger Type Automobile and his or her seat belt is properly fastened.

The Company will pay an additional benefit if a Seat Belt Benefit is payable and if the Insured Employee is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable is equal to 10% of the Insured Employee's Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

The Maximum Amount Payable for this benefit per Insured Employee is listed on the Policy Schedule.

Disability Fitness Benefit

If an Insured Employee suffers Injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, the Company will pay the reasonable and necessary expenses actually incurred for the purchase of any specially designed fitness training or athletic equipment for disabled persons, which would not have been required except for such Injury.

The Maximum Amount Payable for this benefit per Insured Employee is listed on the Policy Schedule. In addition, the Company shall not issue payment for any expense incurred more than two years after the date of the accident.

If the above benefit is available in other policies issued by the Company to the Policyholder, only one benefit shall be payable, the largest, under the policies issued by the Company and shall not duplicate benefits payable under any other insurance.

Parental Care Benefit

If an Injury, for which a benefit is paid or payable hereunder, sustained by an Insured Employee results in a Loss of Life within 365 days of the date of Injury, the Company will pay a Parental Care Benefit for an eligible Dependent Parent.

A Dependent Parent is eligible if, at the time of the accident:

1. He/she is resident in a licensed nursing care facility; or
2. He/she is enrolled in a home health care program; or
3. He/she is living in the Insured Employee's residence; or
4. He/she is receiving support and care provided by the Insured Employee as evidenced by:
 - (a) Cancelled cheques;
 - (b) Income tax returns showing the Dependent Parent as a dependent; or
 - (c) Other similar forms of proof as deemed acceptable by the Company.

The amount of the Parental Care Benefit will be an additional 10% of the Insured Employee's Principal Sum to any Dependent Parents. The Maximum Amount Payable for this benefit per Insured Employee is listed on the Policy Schedule.

The Parental Care Benefit will be payable in equal shares to the Dependent Parents. Only one Dependent Care Benefit will be payable regardless of the number of Dependent Parents.

Carjacking Benefit

If an Insured Employee suffers Injury resulting in Loss for which the Company has paid a benefit set out in the Table of Losses, the Company shall pay an additional amount equal to 10% of the Insured Employee's Principal Sum if Injury causing the Loss is as a result of a Carjacking of a Private Passenger Type Automobile while the Insured Employee is operating, or riding as a passenger in, (including getting in or out of) such Private Passenger Type Automobile.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

The Maximum Amount Payable for this benefit per Insured Employee is listed on the Policy Schedule. Only one benefit is payable under this policy for all Losses as a result of the same Carjacking.

Section 6 : Additional Benefits

These sections of the policy only apply if selected by the Policyholder and the appropriate premium paid.

Subject to the conditions applicable to each of the additional benefits set out below, the Company shall pay additional benefits, up to the maximum amount specified for each such benefit, if an Insured Employee suffers an Injury.

Permanent and Total Disability

If an Insured Employee suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Employee less any amounts under the Table of Losses which have been paid or which are payable by the Company for Losses of the Insured Employee.

Criminal Assault Benefit

If an Insured Employee suffers Injury resulting in Loss for which the Company has paid a benefit set out in the Table of Losses, the Company will pay an additional benefit equal to 10% of the Insured Employee's Principal Sum if such Injury and the resulting Loss are caused by the deliberate act of another person, where such deliberate act:

- (a) constitutes a felony, attempted felony, indictable offence, attempted indictable offence, misdemeanour, attempted misdemeanour, summary conviction offence, attempted summary conviction offence, riot or attempted riot;
- (b) is not a moving violation as defined under the applicable province/state motor vehicle laws;
- (c) is directed at a group of Insured Employees engaged in the usual course of business or at the property or assets of the Insured Employee's Employer, or at the Insured Employee as a representative of the group; and
- (d) is not the act of a fellow employee or a member of the Insured Employee's family or household.

The words act, felony, indictable offence, misdemeanour, summary conviction offence and riot, include, but are not limited to, robbery, theft, bombing, kidnapping, hijacking, larceny, sniping, murder, rioting or inciting a riot. In this Section 6.2, the laws of the jurisdiction where the Injury occurs will govern as to whether an act constitutes a felony, attempted felony, indictable offence, attempted indictable offence, misdemeanour, attempted misdemeanour, summary conviction offence, attempted summary conviction offence, riot or attempted riot.

Cosmetic Disfigurement Benefit

If an Insured Employee suffers Injury resulting in the destruction of his or her skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid (third degree burn or worse), by means of exposure to fire, heat, caustics, electricity or radiation the Company will pay based on a percentage of the Insured Employee's Principal Sum provided that the Insured Employee survives for a period of at least 30 days after the date of the accident causing the burn. The Company will pay depending on the area of the body which is burned and determined in accordance with the following table:

Body Part	(A) Body Classification	(B) Maximum % for that Body Part
Face, Neck, Head	11	99%
Hand & Forearm	5	22.5%
Either Upper Arm	3	13.5%
Torso (front or back)	2	36%
Either Thigh	1	9%
Either Lower Leg (below knee)	3	27%

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the Insured Employee's Body Part that is burned and then multiplying the resulting percentage [not to exceed the Maximum Percentage for that Body Part (B)] by the Principal Sum for such Insured Employee.

The Maximum Amount Payable per Insured Employee for this benefit for all Injuries resulting from any one accident is listed on the Policy Schedule.

Coma Benefit

If an Insured Employee suffers Injury resulting in Loss (other than Loss of Life), and within 90 days of the date of the accident causing Injury the Insured Employee is disabled by coma, which coma is continuous and persistent for a period of six consecutive months at which point the coma is determined by a Physician to be permanent, the Company shall pay 1% of the amount that is:

- (a) the Principal Sum;
- (b) less any other amount paid or payable under this policy in connection with the same accident, Injury or Loss.

This benefit is payable monthly, retroactive to the first complete day of coma, to a maximum of 100 payments per Insured Employee for all Injuries resulting from any one accident.

Surgical Reattachment Benefit

If, as a result of an Injury sustained by an Insured Employee while this policy is in force, a limb or an appendage or part of either a limb or appendage of that Insured Employee is completely severed while this policy is in force, and if such limb, appendage or part is surgically reattached to that Insured Employee, then the Company will pay a Surgical Reattachment Benefit to such Insured Employee in accordance with the following:

- (a) whether or not the Insured Employee regains use of the severed limb, appendage or part, the Company will pay a benefit that is equal to 50% of the specific, accidental loss benefit that would have been payable for the severance of such limb, appendage or part under the Table of Losses section if the surgical reattachment had not been performed;
- (b) if, within 365 days immediately after the reattachment of the severed limb, appendage or part, the Insured Employee suffers a total, irrevocable and permanent loss of use of such

reattached limb or part of a limb, the Insurer will pay a benefit that is equal to the benefit under the Table of Losses section for loss of use of such limb or part of a limb minus the amount(s) paid or payable under this Surgical Reattachment Benefit provision;

- (c) if, within 365 days immediately after the reattachment of the severed limb, appendage or part, such reattachment fails and the limb, appendage or part must be amputated, the Company will pay a benefit that is equal to the benefit under the Table of Losses section for the specific, accidental loss of such limb, appendage or part minus the amount(s) paid or payable under this Surgical Reattachment Benefit provision.

War Risk Coverage

War Risk Coverage shall not be afforded nor shall it come into effect unless the Policyholder has paid the deposit premium. Further, War Risk Coverage shall not be maintained unless the Policyholder provides an exposure report that conforms to the Reporting Requirements.

Notwithstanding the Section 12.3(c) of the policy, the Company will afford to certain Insured Employees who qualify for coverage under this policy for Injury or Loss caused by or resulting from an act of declared or undeclared war within the geographical limits or territorial waters of, or airspace above the geographic limits or territorial waters of, a Designated War Risk Territory(ies) (but not such an act in which the Insured Employee is an active participant).

The maximum amount payable for Injury or Loss caused by or resulting from an act of declared or undeclared war is the lesser of:

- (a) the Principal Sum specified in the Policy Schedule; and
- (b) the Maximum Amount Payable per Insured Employee per Accident listed in the Policy Schedule.

Changes in Premium: The Company may change the premium rate for the inclusion of War Risk Coverage under this policy at any time if:

- (a) war risk conditions change in the Designated War Risk Territory(ies);
- (b) there is a change in which area(s) is (are) defined to be the Designated War Risk Territory(ies); or
- (c) the Policyholder's exposure to war risk in the Designated War Risk Territory(ies) changes in any way.

The Company will give the Policyholder written notice of any change in the premium rate for the inclusion of War Risk Coverage at least 30 days in advance of the effective date of the change.

Termination Date: War Risk Coverage ceases to apply with respect to this policy on the earliest of:

- (a) the date the policy terminates;
- (b) the date the Company receives written notice from the Policyholder of the Policyholder's intent to terminate the applicability of the War Risk Coverage (or on the date specified in the written notice, if later); or

- (c) the date specified in the Company's written notice to the Policyholder of the Company's intent to terminate the applicability of War Risk Coverage (but in no event shall coverage terminate in less than 10 days after such notice is mailed or delivered).

If the applicability of War Risk Coverage terminates prior to the end of a period for which premium has been paid, any unearned premium attributable to the War Risk Coverage will be returned.

Termination of the applicability of the War Risk Coverage will not affect a claim for a covered loss that occurred while the War Risk Coverage was still applicable.

Notwithstanding any other provision of this contract:

1. the War Risk Coverage shall automatically terminate upon the occurrence of war among the major powers of Europe or Asia; and
2. the Company will not be liable to provide any coverage or make any payment hereunder if to do so would be in violation of any sanctions law or regulation which would expose the insurer, its parent company or its ultimate controlling entity to any penalty under any sanctions law or regulation.

War Risk Coverage Additional Definitions

In addition to the general policy definitions, words with a special meaning in this section are listed below and are shown with Initial Capital Letters.

Designated War Risk Territory(ies): as used in Section 6.5, means named country(ies) or part(s) of country(ies) included on the war risk country listing maintained by the Company. A Designated War Risk Territory does not include Canada or the United States of America or the Insured Employee's country of permanent residence.

Reporting Requirements: The Policyholder agrees to report, in writing, exposure of Insured Employees in the Designated War Risk Territory(ies) annually. For select Designated War Risk Territory(ies) as identified on the war risk listing, pre-approval by the Company is required and monthly reporting may be required until further notice. The report must include the name and occupation of each Insured Employee, reason for travel, his or her specific itinerary and destination(s) in the Designated War Risk Territory(ies) including the exact location to which the Insured Employee intends to travel, the effective and termination dates of his or her exposure, and his or her Principal Sum with respect to War Risk Coverage during the period of exposure.

Section 7 : Serious Illness

This section of the policy only applies if selected by the Policyholder and the appropriate premium paid.

Serious Illness Benefit

If a person has been an Insured Employee under this policy for not less than 90 consecutive days following which the Insured Employee is Diagnosed with any one of the Serious Illnesses defined below, the Company will pay 10% of the Insured Employee's Principal Sum, up to the Maximum Amount Payable listed on the Policy Schedule, provided that the Insured Employee:

- (a) was not Diagnosed with one of the Serious Illnesses ever before;

- (b) completes the Survival Period applicable to the Serious Illness causing reason to claim; and
- (c) is under the age of 65 at the time of the Diagnosis.

The Serious Illness benefit is payable only once, regardless of the number of Serious Illnesses the Insured Employee may have or be Diagnosed with.

Serious Illness Additional Definitions

In addition to the general policy definitions, words with a special meaning in this section are listed below and are shown with Initial Capital Letters.

Diagnosis or **Diagnosed** means the certified written Diagnosis of a Serious Illness suffered by the Insured Employee made by a Medical Doctor. The date of Diagnosis shall be the date the Diagnosis is established by the Medical Doctor, as supported by medical records.

Irreversible means the medical condition/limitations cannot be materially improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if its experimental or would involve undue risk to the Insured Employee's health.

Life Support means the Insured Employee is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

Medical Doctor means an individual who is legally licensed and practicing medicine or surgery in Canada, and specializes in a particular area of medicine for the purpose of making a Diagnosis of any of the Serious Illnesses eligible for payment under this Policy, and who is not the Insured Employee or the Insured Employee's Immediate Family or business associate.

Medical Doctor does not include a chiropractor, naturopath, homeopath, dentist, podiatrist or optometrist.

Pre-existing Condition means: a) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 24-month period preceding the Insured Employee's Effective Date or b) an illness or condition for which the Insured Employee, during 24 months prior to the Effective Date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a Medical Doctor.

If an Insured Employee was covered for at 24 months under a prior group policy providing similar coverage for one or more of the Serious Illnesses and for all or a portion of the Principal Sum, the Pre-Existing Condition exclusion under this group policy, will not apply to the Serious Illness for which there was coverage under the prior group policy, to the extent of the amount insured under the prior group policy.

If an Insured Employee was covered for less than 24 months under a prior group policy providing similar coverage for one or more of the Serious Illnesses and for all or a portion of the Principal Sum, the time period for the Pre-Existing Condition exclusion under this group policy, shall be reduced by the number of months for which there was coverage under the prior group policy, to the extent of the amount insured under the prior group policy.

Any benefit amount provided in this group policy that exceeds the benefit amount for such Serious Illness covered under a prior group policy, will be subject to the terms of this exclusion.

The prior group policy must be cancelled within 31 days prior to the Effective Date of this group policy.

Serious Illness refers to an illness, medical condition or procedure as listed as a Serious Illness. No benefit shall be payable for an illness, medical condition or procedure not listed under the Serious Illnesses.

Survival Period means the minimum number of consecutive days (excluding the number of days on Life Support), immediately following the date of Diagnosis, which the Insured Employee must survive before a Serious Illness benefit amount may become payable. The Survival Period is 30 days unless a longer period is specified in the definition of a Serious Illness. Serious Illness eligible claims become payable after the expiry of the Survival Period for that Serious Illness

The term "Serious Illness" includes only the following illnesses, medical conditions, procedures or surgeries as defined below:

1) MAJOR ORGAN FAILURE ON WAITING LIST

Major Organ Failure on waiting list means the Diagnosis of the Irreversible failure of the heart, liver, both lungs or both kidneys requiring receipt of a transplant of that organ, resulting in the Insured Employee being accepted into a recognized transplant program in Canada. For purposes of the Survival Period, the date of Diagnosis is the date the Insured Employee is enrolled into the transplant program.

**2) MAJOR ORGAN
TRANSPLANT**

Major Organ Transplant means the Diagnosis of Irreversible failure of the heart, liver, both lungs or both kidneys as a result of which transplantation is medically necessary. A transplantation that is not medically necessary is specifically excluded.

3) MOTOR NEURON DISEASE

Motor Neuron Disease means an unequivocal Diagnosis of amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), primary lateral sclerosis, progressive bulbar palsy, or pseudo-bulbar palsy. Other variations of motor neuron disease are specifically excluded.

4) MULTIPLE SCLEROSIS

Multiple Sclerosis shall mean the definite Diagnosis by a neurologist of at least one of the following:

- (a) two or more separate clinical attacks, confirmed by modern imaging technology (MIT) of the nervous system, showing multiple lesion of demyelination;
- (b) well-defined neurological abnormalities persisting for a continuous period of at least 180 days, confirmed by (MIT) of the nervous system, showing multiple lesion of demyelination; or
- (c) a single attack confirmed by repeated (MIT) of the nervous system, showing multiple lesions of demyelination that have developed at intervals at least one month apart;

5) NECROTIZING FASCIITIS

Necrotizing Fasciitis means an unequivocal Diagnosis of insidiously advancing soft tissue infection of the deeper layers of skin and subcutaneous tissues (fascia).

6) PARKINSON'S DISEASE

Parkinson's Disease means the definite Diagnosis of primary idiopathic Parkinson's Disease by a consultant neurologist, which must be characterized by bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses) and at least of one of the following clinical manifestations: muscle rigidity or tremor. The Insured Employee must require substantial physical assistance from another adult to perform two or more of six Activities of Daily Living for a continuous period of six (6) months or more.

The following are excluded:

- Non-organic diseases such as neurosis and psychiatric illnesses;
- Alcohol related brain damage;
- Drug-induced or toxic causes of Parkinsonism;
- All other types of Parkinsonism.

Exclusions - In addition to the General Exclusions applying to all Sections

The Serious Illness Benefit will not be paid for any loss resulting in whole or in part from, or expenses incurred, directly or indirectly in respect of:

- (a) Any Pre-existing Condition or any complication arising from such Pre-existing Condition;
- (b) Any Serious Illness resulting from any condition which existed before the Insured Employee's Effective Date;
- (c) An intentionally self-inflicted Injury or sickness;
- (d) Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel;
- (e) The radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment;
- (f) Congenital anomalies or any complications or conditions arising therefrom;
- (g) Any loss resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy,
- (h) Any Serious Illness based on a Diagnosis made by the Insured Employee or his/her Immediate Family Member or anyone who is living in the same household as the Insured Employee or by a herbalists, acupuncturist or other non-traditional health care provider;
- (i) Cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non-surgical treatment of obesity (including morbid obesity) and weight control programs, or treatment of an optional nature;

- (j) Any loss resulting from the abuse of alcohol, drugs or narcotics;
- (k) Any Serious Illness if the Insured Employee does not survive the applicable Survival Period;
- (l) A Serious Illness for which the Insured Employee receive medical advice, had symptoms or tests, or receive any medication or treatment within the first 90 consecutive days of the Effective Date;
- (m) Any Illness that is not specifically defined as a Serious Illness in this policy.

Section 8 : Waiver of Premium

In the event an Insured Employee is accepted and approved under his or her Employer's current group life policy for total disability waiver of premium, then as of the effective date of such group life waiver of premium, the premiums payable under this policy are waived in connection with such Insured Employee until the first to occur of the following:

- (a) the date the Insured Employee attains age 65;
- (b) the date of the death or recovery of the Insured Employee;
- (c) the date the Insured Employee is no longer eligible for total disability waiver of premium under the Policyholder's group life policy; and
- (d) the date the insurance of an Insured Employee ends.

Section 9 : Continuance of Coverage

In the case of a person who was an Insured Employee who is no longer employed or actively working, the Company shall extend coverage for such person in the following circumstances: (1) during a statutory leave, as set out in applicable provincial, territorial or federal employment standards legislation or equivalent, but not more than the period required under such legislation, or (2) during the notice period for termination of employment as required by law , subject to payment of premium by the Policyholder for each such person.

Further, if during a statutory leave or during the notice period of termination of employment, such person assumes other occupational duties not related to the operations of the Policyholder, no benefits are payable for any Loss resulting from any Injury which occurs during the performance of said other occupational duties.

Section 10 : Conversion Privilege

On the date of an Insured Employee's termination of employment or during the 90 day period following termination of employment, the employee may elect to convert his or her coverage for accidental Loss of Life under this policy to an individual insurance policy of the Company providing comparable coverage. Such individual policy, if conversion is elected, will be effective either as of the date that the employee's application is received by the Company within the 90 days after the termination of employment or on the date that coverage under this policy ceases, whichever occurs later. The premium will be the same premium ordinarily available for individual policies of the Company as at that time. Application for an individual policy may be made at any office of the Company.

The amount of insurance benefit provided for in the new policy shall not exceed the lesser of \$500,000 or the Insured Employee's Principal Sum, as at the effective date of his or her termination of employment with the Employer.

Section 11 : Beneficiary Designation

The Insured Employee may designate a beneficiary to receive the amount payable hereunder for his or her Loss of Life.

In the absence of such a beneficiary designation, the beneficiary to receive the benefit payable hereunder as set out in the Table of Losses for Loss of Life of the Insured Employee is the person or persons who is or are on file with the Insured Employee's Employer as having been most recently designated by the Insured Employee for the purposes of the Employer's basic group life insurance policy to receive the death benefit under such policy. In the absence of any such designation validly made for the purposes of the Employer's current basic life insurance policy the beneficiary shall be the estate of the Insured Employee.

In the absence of such a beneficiary designation or contingent designation, the benefit for Loss of Life of an Insured Employee shall be payable to the estate of the Insured Employee.

Section 12 : Exclusions and Limitations

Limitations

The maximum amount payable per Insured Employee under this policy for Losses sustained by any one Insured Employee as the result of any one accident is the Principal Sum, except where a Loss is Quadriplegia, Paraplegia or Hemiplegia, in which case the maximum amount payable per Insured Employee is the amount indicated for such Loss in the Table of Losses. This limitation does not apply to the additional benefits set out in Section 5.3 – 5.19, Section 6 and Section 7 which are subject to their own specific limits.

Aggregate Limit per Accident

The maximum amount payable by the Company under this policy for two or more Insured Employees who suffer an Injury in any one accident is the amount which is the Aggregate Limit per Accident set out in the Policy Schedule Declarations.

If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit per Accident, the Company shall not be liable to any one Insured Employee for any amount in excess of the

Aggregate Limit per Accident. Each injured Insured Employee's benefits shall be a portion of the benefits to which they otherwise would have been entitled hereunder. That portion shall be the proportion of what the Company would have paid hereunder to the Insured Employee relative to what the Company would have paid hereunder to all Insured Employees who suffered an Injury in such accident but for the Aggregate Limit per Accident.

Exclusions

No coverage shall be provided under this policy and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

- (a) suicide or any attempt thereof by the Insured Employee;
- (b) self-inflicted Injury or any attempt thereof by the Insured Employee;
- (c) declared or undeclared war or any act thereof;
- (d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;
- (e) Injury sustained while the Insured Employee is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
- (f) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;
- (g) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft, if the Insured Employee is:
 - (i) riding as a passenger in any Aircraft not intended or licenced for the transportation of passengers; or
 - (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
 - (iii) riding as a passenger in an Owned Aircraft, Leased Aircraft or on a Charter Flight.
- (h) travel or flight in or on (including getting in or out of, or on or off of) any Aircraft or any craft designed to fly or glide above the Earth's surface:
 - (i) except as a passenger on a regularly scheduled commercial airline; or
 - (ii) being used for crop dusting, spraying or seeding, fire-fighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
 - (iii) operating to or from off-shore landing sites; or

- (iv) used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).
- (i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
- (j) Injury or Loss sustained while the Insured Employee is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Employee is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
- (k) Injury or Loss sustained while the Insured Employee is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while his or her blood alcohol is over 80 milligrams in 100 millilitres of blood;
- (l) Injury or Loss sustained while the Insured Employee is under the influence of a drug or substance which is controlled as specified under the Controlled Drugs and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;
- (m) the commission or attempted commission by an Insured Employee or Injury incurred while an Insured Employee is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed;
- (n) an act, attempted act or omission taken or made by the Insured Employee, or an act, attempted act or omission taken or made with the Insured Employee's consent, for the purposes of interrupting the blood flow to the Insured Employee's brain or to cause asphyxiation to the Insured Employee whether with intent to cause harm or not; and
- (o) natural causes.

Section 13 : General Provisions

These General Provisions are applicable to this policy as a whole. Please read each section to see further additional conditions and provisions relating to that section.

The Policy

The policy between the Policyholder and the Company consists of:

- (a) this document,
- (b) the Policy Schedule; and
- (c) any written amendment(s) to this document issued by the Company.

The policy can be changed or amended without the consent of any Insured Employee.

Amendments

Only the Chief Agent of the Company or his or her authorized representative has authority to waive or agree to amend any part of this policy on behalf of the Company.

Waiver

The Company shall be deemed not to have waived any condition of this policy, either in whole or in part, unless the waiver is clearly expressed in writing and signed by the Company.

Right To Return Policy

The Policyholder may return this policy for any reason within the later of: (1) 15 days after receiving it; or (2) 15 days after the coverage becomes effective. It may be returned by e-mail or in person to the Company. Any premium paid will be refunded and this policy will be treated as if it were never issued.

Notice

Any notice required or permitted to be given to or by the Policyholder or the Company pursuant to this policy shall be in writing and shall be deemed to be properly given if sent by prepaid registered mail to the applicable party at the address indicated on the Policy Schedule.

Notice and Proof of Claim

The Policyholder or its agent, the Insured Employee or an Insured Employee's beneficiary entitled to make a claim or his or her agent:

- (a) Shall give written notice of claim to the Company by delivery thereof, or by sending it by mail or email not later than 30 days from the date of the accident;
- (b) Within 90 days from the date of the accident or the Injury, furnish to the Company such proof of claim as is reasonably possible in the circumstances of the happening of the accident or Injury occasioned thereby; and
- (c) If so required by the Company, furnish a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the Injury or Loss, from a legally qualified medical practitioner.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed in Section 13.6 will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the Injury and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

Right of Examination

The Company has the right, and any Insured Employee making a claim shall afford to the Company an opportunity, to examine him or her when and as often as the Company may reasonably require while the claim hereunder is pending, and also, in the case of the Loss of Life of an Insured Employee, to make an autopsy subject to any law of the Insured Employee's province of residence relating to autopsies.

When Moneys Payable

The Company shall pay, within 60 days after it has received sufficient proof of claim and the person entitled to benefits in connection with such claim, all moneys payable under this policy.

Limitation of Actions

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* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), *The Limitations Act* (for actions or proceedings governed by the laws of Saskatchewan) or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the *Quebec Civil Code*.

Payment of Claims

The benefit payable for Loss of Life will be payable in accordance with Section 11. Unless otherwise specified herein:

- (a) any accrued other benefits payable but unpaid at the Insured Employee's death will be paid to the Insured Employee's estate; and
- (b) all other benefits are payable to or on behalf of the Insured Employee.

Section 14 : Additional Provisions

Currency

All moneys payable under this policy are payable in the lawful money of Canada unless otherwise stated.

Assignment

The Policyholder cannot assign this policy without the consent of the Company. Neither the insurance provided hereunder nor benefits payable hereunder may be assigned.

Non-Participating

Neither the Policyholder nor any Insured Employee is entitled to share in the profits or surplus of the Company.

Governing Law

The relationship between the Company and the Policyholder shall be governed by and interpreted in accordance with the laws of the Province of Ontario.

The relationship between the Company and any Insured Employee shall be subject to the laws of the Insured Employee's Canadian province or territory of residence at the time his or her insurance coverage hereunder comes into effect.

Conformity with Applicable Law

Any provision of this Policy, which is in conflict with any federal, provincial, territorial or other applicable law of an Insured Employee's place of residence, is hereby amended to conform to the minimum requirements of that law.

The Company will not be liable to provide any coverage or make any payment hereunder if to do so would be in violation of any sanctions law or regulation which would expose the Company, its parent company or its ultimate controlling entity to any penalty under any sanctions law or regulation.

This policy will not cover any loss, injury, damage or legal liability arising directly or indirectly from planned or actual travel in, to, or through Iran, Syria, Sudan, North Korea or the Crimea region.

Not In Lieu of Workers' Compensation

This policy is not in lieu of and does not affect any requirement for coverage under workers' compensation legislation or similar law.

Collective Agreement and this Policy

This policy shall take precedence in the event of an inconsistency between this policy and any collective agreement which applies to the Insured Employee and to which the Policyholder or the Employer is a party.

By signing below, the President and Chief Executive Officer of the Insurer agrees on behalf of the Insurer to all the terms of this Policy.



President and Chief Executive Officer
AIG Insurance Company of Canada

This Policy shall not be valid unless signed at the time of issuance by the President and CEO of the Insurer.

Despite any other provision of this policy, this policy is subject to the statutory conditions in the Insurance Act respecting policies of accident and sickness insurance.

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at www.sunlife.ca/privacy or call us for a copy.

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).

