Contract Number: 103504, 150202 and GPA 9109375
Effective: May 1, 2026
Issued: July 3, 2026

your group benefits

VIA Rail Canada Inc.

Union TCRC

VIA Rail Canada

Sun Life Financial

Table of Contents

How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-866-881-0583.

For faster service, have your **group contract number** and **member ID** ready to enter into our automated telephone system.

Plan Member Services

Download the my Sun Life Mobile App!

- Free from the Apple App Store or Google Play, anytime
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

Access to mysunlife website

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

Prior Authorization Program

For the form:

- visit our website at www.mysunlife.ca/priorauthorization
- call a Sun Life Financial Customer Care representative toll-free at 1-866-881-0583

For the list of drugs and supplies:

- visit our website at www.mysunlife.ca/priorauthorization

Your Drug Card

Visit www.mysunlife.ca to obtain your card.

Note: If you have refused Extended Health Care coverage under this plan, this drug card does not apply to you.

Your Travel Card

Visit www.mysunlife.ca to obtain your card.

Note: If you have refused Extended Health Care coverage under this plan, this travel card does not apply to you.

Need to contact Sun Life’s Emergency Travel Assistance provider?

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

All other inquiries

Call 1-866-881-0583.

Benefit Summary

The information contained in this summary applies only to benefits insured by Sun Life Assurance Company of Canada. The Basic Accidental Death & Dismemberment benefit described later in this booklet is not insured by Sun Life.

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Waiting period	3 months of continuous service Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care - Contract Number 103504

Benefit year	January 1 to December 31
Deductible	Prescription drugs – $4 for each prescription or refill Other expenses: • individual – $25 per benefit year • family – $25 per benefit year For employees residing in Québec, the deductible that applies to Prescription drugs ceases to be applied for drugs and supplies listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached
Reimbursement level	
Drug card plan	Included
Prescription drugs	80% after the deductible For employees residing in Québec, the reimbursement percentage is increased to 100% for drugs and supplies listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached. However, if the drug submitted for reimbursement has a lower priced equivalent drug, only the cost of the lowest priced equivalent drug will be considered at 100%, unless Sun Life specifically approved the cost of the higher priced drug.

To be eligible under Prescription drugs, drugs and supplies must have a Drug Identification Number (DIN) or Product Identification Number (PIN) and, when applicable, be approved under *Evaluation of drugs and supplies*

Of these eligible drugs and supplies, we will cover the following when prescribed by a doctor or dentist and 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
- diabetic supplies. However, if a limit or other eligibility criteria are specified for certain diabetic supplies, either under this list of eligible expenses or under *Medical services and equipment*, then such limit or criteria will apply to those supplies.
- Continuous Glucose Monitoring (CGM) systems and their parts, including both intermittently scanned and real-time monitors, as determined by us, up to a combined maximum of $4,000 per person per benefit year, subject to any clinical criteria that we may require
- products to help a person quit smoking that legally require a prescription, up to a maximum of $700 per person per benefit year
- vaccines, up to a maximum of $500 per person per benefit year
- intrauterine devices (IUDs) and diaphragms
- varicose vein injections

Certain services, drugs, supplies or treatments may not be covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.

Other health professionals allowed to prescribe drugs and supplies

If applicable provincial legislation allows:

- other qualified health professionals to prescribe certain drugs or supplies, or
- pharmacists, in providing pharmacy services, to recommend and dispense certain drugs and supplies,

then we will reimburse these drugs and supplies prescribed by other qualified health professionals or recommended and dispensed by a pharmacist, as applicable, the same way we would if a doctor or dentist prescribed them.

Drug substitution limit

We will not cover charges above the lowest priced equivalent drug unless we specifically approve them. To assess the medical necessity of a higher priced drug, we will require the covered person and the attending doctor to complete and submit an exception form.

For employees residing in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless we specifically approved the charges for the higher priced drug

Québec drug insurance plan

For employees residing in Québec, any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements

In-province hospital

100%, without the deductible, of the difference between the cost of a ward and a semi-private room

Convalescent hospital

100%, without the deductible, up to $20 per day for a maximum of 120 days per stay

Hospice

100% without the deductible

Out-of-province emergency services	100% without the deductible Emergency Travel Assistance included Time limit – 90 days after the date the person leaves the province where the person lives Lifetime maximum of $3,000,000 per person for out-of-Canada services
Out-of-province referred services	80% without the deductible
Medical services and equipment	80% after the deductible
Gender affirmation procedures	100%, after the deductible, up to a maximum of $15,000 per person per benefit year but no more than $50,000 in a person's lifetime
Paramedical services	80%, after the deductible, up to a combined maximum of $750 per person per benefit year for all the qualified paramedical practitioners listed below: • massage therapists • speech therapists • audiologists • osteopaths or osteopathic practitioners, including a maximum of one x-ray examination each benefit year • chiropractors, including a maximum of one x-ray examination each benefit year • podiatrists or chiropodists, including a maximum of one x-ray examination each benefit year 80%, after the deductible, up to a combined maximum of $1,000 per person per benefit year for all the qualified paramedical practitioners listed below: • psychologists • social workers 80%, after the deductible, up to a combined maximum of $1,250 per person per benefit year for all the qualified paramedical practitioners listed below: • physiotherapists • athletic therapists
Vision care	Contact lenses, eyeglasses or laser eye correction surgery – 80%, after the deductible, up to a maximum of $450 in any 12 month period for a person under age 18 or in any 24 month period for any other person Ophthalmologist or licensed optometrist – 80%, after the deductible, up to a maximum of $75 in any 12 month period for a person under age 18 or in any 24 month period for any other person
Termination	When you retire
At retirement	For more information about coverage after retirement, please contact your employer

Dental Care - Contract Number 103504

Benefit year	January 1 to December 31
Deductible	Individual – $35 per benefit year Family – $35 per benefit year
Fee guide	The current fee guide in the province 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	
Preventive procedures	100% after the deductible
Basic procedures	Endodontics and periodontics – 80% after the deductible Other procedures – 100% after the deductible
Major procedures	50% after the deductible
Orthodontic procedures	50%, without the deductible, only for children under age 21
Maximum benefit	
Benefit year maximum	$2,500 per person If your coverage starts in the second half of a benefit year, the maximum amount for that benefit year will be reduced by 50% A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime maximum	Orthodontic procedures – $3,000 per person
Termination	When you retire

Personal Spending Account - **Contract Number 150202**

Benefit year	May 1, 2026 to December 31, 2026, and then from January 1 to December 31
Credits	$200 at the beginning of each benefit year
Termination	When you retire

Short-Term Disability - **Contract Number 103504**

Maximum amount	70% of your weekly basic earnings up to a maximum of $1,100 The maximum amount may be reduced by benefits and payments provided from other sources as described in the *Short-Term Disability* section of your booklet.

Coordination with employment insurance sickness benefits for employees that are eligible to receive employment insurance sickness benefits	Employment insurance sickness benefits are included in the benefits from other sources described in the *Short-Term Disability* section of your booklet Employment insurance sickness benefits are normally paid from the 16th week through the 41st week of total disability and are coordinated with your Short-Term Disability benefit payments as described below If your Short-Term Disability claim is approved: • you will be eligible for Short-Term Disability benefit payments for the period between the end of the elimination period and the end of your 15th week of total disability • for the 16th week through the 41st week of total disability, you may receive both Short-Term Disability benefit payments and employment insurance sickness benefits, however, your Short-Term Disability benefit payments will be reduced by the amount of any employment insurance sickness benefits payable to you • after 41 weeks of total disability, you will be eligible for Short-Term Disability benefit payments until the end of the maximum benefit period
Elimination period	Accident – none Illness – 3 days of uninterrupted total disability or the period up to the day you are hospitalized, whichever is shorter. To be considered hospitalized, you must have either: • been admitted in a hospital overnight as an in-patient • been admitted in a hospital as an outpatient and have undergone a surgical intervention • undergone a procedure under general or epidural anaesthesia in either a hospital, medical clinic or doctor's office
Maximum benefit period	If you are not eligible to receive employment insurance sickness benefits – 26 weeks If you are eligible to receive employment insurance sickness benefits – 41 weeks Benefits may also end on an earlier date as specified in the *Short-Term Disability* section of this booklet
Doctor's charges for the completion of claim forms	We will cover doctor's charges for the completion of Short-Term Disability claim forms, other than claim forms required for the following: • initial declaration. • to authorize return to work. • to appeal a decision for which we did not communicate directly with the attending doctor. The maximum amount payable is $30 per form.
Termination	When you retire
Tax status	Your employer has indicated that it is paying all or a portion of the premium for this disability plan. Therefore, the benefit payments are taxable income.

Life - Contract Number 103504

Employee Life

Amount	$75,000

Termination	When you retire
At retirement	For more information about coverage after retirement, please contact your employer

Making Claims

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

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

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

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

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Ask Sun Life for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask Sun Life.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which you incur the expenses, or • 90 days after the end of your Extended Health Care coverage.
Emergency Travel Assistance	Contact Sun Life's Emergency Travel Assistance provider to notify them that a medical emergency exists.	**Having expenses reimbursed:** To have services or supplies reimbursed that either you or another covered person have paid for, proof of the expenses must be provided to us within 30 days of the person's return to the province where the person lives. Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.

Type of claim	Starting the claims process	Limits and special instructions
Dental Care	Ask Sun Life for the form to complete, or get the form on our website. Your dentist will have to complete a section of the form. You can also submit claims for some expenses electronically. For more information, ask Sun Life.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which you incur the expenses, or • 90 days after the end of your Dental Care coverage. If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information. For orthodontic procedures, a treatment plan will need to be submitted to us.
Personal Spending Account	Ask Sun Life for the form to complete, or get the form on our website. You can also submit your claims electronically.	Up to 90 days after the earlier of the following dates: • the end of the benefit year during which the expense is incurred, or • the end of your Personal Spending Account coverage.
Short-Term Disability	Ask your employer for the claim forms, and ensure that the following people complete them: • you • your attending doctor • your employer.	Up to 30 days after your total disability begins. We will assess the claim and send you or your employer a letter that outlines 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	Ask Sun Life to provide the claim forms.	**If the claim is a result of a death:** We must receive the claim form as soon as possible after the death occurred. **For Coverage during total disability:** We must receive the proof of total disability within 12 months of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

General Information

The information contained in this section applies only to benefits insured by Sun Life Assurance Company of Canada. The Basic Accidental Death & Dismemberment benefit described later in this booklet is not insured by Sun Life.

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

The booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Talk to your employer.

Your group benefits	The contract holder, VIA Rail Canada Inc., has established a Personal Spending Account and entered into a Personal Spending Account Services Contract with Sun Life. The contract holder has the sole legal and financial liability for the Personal Spending Account and Sun Life only acts as administrator. All other benefits are insured by Sun Life.
Who is eligible to receive benefits?	To be eligible for group benefits, you must live in Canada and meet all the following conditions: • you are a permanent employee working in Canada. • you are actively working for your employer and hold a full-time or part-time unionized position in accordance with the applicable collective agreement. • you have completed the waiting period indicated in the Benefit Summary. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent. You must apply for coverage for yourself in order for your dependents to be eligible.
Who qualifies as your dependent	Your dependent must be: • your spouse or your child, and • residing in Canada or the United States. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage. • under any other formal union recognized by law. • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least 12 months. For employees residing in Québec, there is no minimum cohabitation period if a child is born out of the 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 under age 21 and do not have a spouse. A child who is a full-time student under age 26 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse. **If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask Sun Life for more on this.**
How to enrol	*For you* – You must provide the proper enrolment information to Sun Life. *For a dependent* – You must ask for dependent coverage. If you or your dependents already have similar Extended Health Care or Dental Care coverage under this or another plan – You may refuse this coverage under this plan. If the other coverage ends at a later date, you can enrol for coverage under this plan then.
When coverage begins	Your coverage begins on the date you become eligible for coverage. If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work. A dependent's coverage begins **on the later of** the following dates: • the date your coverage begins. • the date you first have a dependent.
Changes affecting your coverage	If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health. If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to Sun Life: • change of dependents. • change of name. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies.

Need a copy of a document? Contact one of the following:

- our website at www.mysunlife.ca.
- our Customer Care centre, toll-free at 1-866-881-0583.

When coverage ends

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

- the date your employment ends for any reason other than retirement on pension.
- the date you are no longer actively working, except as stated under Continuation of Coverage.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract or the benefit provision ends.

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

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

The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

Continuation of Coverage

When coverage would terminate because your employment ends or because you are no longer actively working, your employer is entitled to continue your coverage in the following circumstances:

- during a maternity leave, parental leave or adoption leave, up to a maximum of 52 weeks, unless the period required under the applicable employment standards legislation is longer. You are not required to pay the premiums during this period for this coverage to continue.
- during a compassionate care leave, up to a maximum of 28 weeks, unless the period required under the applicable employment standards legislation is longer. You are not required to pay the premiums during this period for this coverage to continue.
- during a military leave for reservists.
- during the period in which you are no longer actively working due to an illness or accident, provided that your employment continues:
    - for Employee Life coverage – during a period of 10 months from the end of the month in which the disability occurs. If you are receiving disability benefits from Sun Life or employment insurance sickness benefits, you are not required to pay the premiums during this period. If the disability continues beyond this period, you may extend coverage for another 2 months if you pay the required premiums.
    - for the Extended Health Care benefit – during a period of 104 weeks from the end of the month in which the disability occurs. If you are receiving disability benefits from Sun Life or employment insurance sickness benefits, you are not required to pay the premiums during this period. If the disability continues beyond this period, you may extend coverage for another 6 months if you pay the required premiums.
    - For the Dental Care benefit – during a period of 12 weeks. You are not required to pay the premiums during this period for this coverage to continue.
- during the period in which you are no longer actively working following a work injury, provided that your employment continues. You are not required to pay the premiums during this period for this coverage to continue.
- during the notice period for termination of employment as required by relevant

	legislation.
	• during an educational leave, lay-off or approved personal leave (for any other reason other than those indicated above), up to the last day of the month during which the leave began, for Employee Life coverage and the Extended Health Care benefit. You may extend coverage for another 12 months if you pay the required premiums. Your employer's decision must be applied equally to all employees within the same classification.

If you die while covered by this plan

Coverage for your dependents will continue, without anyone paying further 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 your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

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

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 continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total eligible expenses.

When you have more than one plan, insurance industry standards determine which plan you should claim expenses from first.

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

- First, send in the claim to the plan where the person is covered as an employee. If the person is an employee under two plans, send the claim to the different plans in the following order:
  - to the plan where the person is covered as an active full-time employee.
  - then, to the plan where they are covered as an active part-time employee.
  - then, to the plan where they are covered as a retiree.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

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

When you send us a claim, you must tell us about all other equivalent coverage that you or your dependents have.

Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefit.

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us.
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits appear in the benefit sections.

Accident	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
Appropriate treatment	Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.
Basic earnings	Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.
Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Illness	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.
Retirement date	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

Extended Health Care

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 Extended Health Care benefits.

Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

Eligible expenses mean expenses:

- incurred for the services, drugs and supplies:
  - medically necessary for the treatment of an illness and
  - meeting other requirements described below.
- not exceeding the reasonable and customary charges for the service, drug or supply.

Supplies include equipment, devices and other similar items.

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

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services, drugs or supplies are provided, and
- charges for services, drugs and supplies that represent reasonable treatment, considering their duration, quantity and frequency.

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

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

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date the services, drugs or supplies are received, purchased or rented, as applicable. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Deductible and reimbursement level	The deductible is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the deductible and the reimbursement level are indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs and supplies, in a 100 day period as ordered by a doctor.
What is not covered	We will not pay for the following, even when prescribed: • infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments. • the cost of giving injections, serums and vaccines. • treatments for weight loss, including drugs, proteins and food or dietary supplements. • hair growth stimulants. • drugs for the treatment of infertility. • drugs for the treatment of sexual dysfunction. • drugs that are used for cosmetic purposes. • natural health products, whether or not they have a Natural Product Number (NPN). • drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Evaluation of drugs and supplies	The following will be evaluated and must be approved by us to be eligible or to continue to be eligible for coverage:
	• drugs when Health Canada issues a new or amended Notice of Compliance on or after November 1, 2017.
	• supplies initially made available for sale on the Canadian market on or after March 1, 2026.
	• drugs or supplies covered under this plan on March 1, 2026 or subsequently covered, after which, they undergo change(s) or are affected by changes relevant to our eligibility criteria, including changes to:
	  • drug or supply costs.
	  • clinical guidelines.
	  • new versions or modifications to a drug or supply.
	Drug and supply expenses are eligible for reimbursement only if incurred on or after the date of our approval.
	The eligibility criteria relevant to our initial and ongoing evaluation of drugs and supplies include:
	• comparative analysis of the cost of the drugs or supplies and their clinical effectiveness.
	• recommendations by health technology assessment organizations.
	• coverage under government programs.
	• availability of other drugs and supplies treating the same or similar condition(s).
	• plan sustainability.

Pharmaceutical services (rendered by pharmacists)	For employees residing in Québec, we will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

Prior authorization program	The prior authorization (PA) program applies to select drugs and supplies which require prior approval before a claim is reimbursed. For your claim to be reimbursed, you must meet the clinical criteria determined by us. We will assess if you meet the clinical criteria based on information provided by you and your attending doctor. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form. If you submit a claim for a drug or supply included in the PA program without obtaining prior approval, your claim will be declined. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.
Out-of-pocket maximum	For employees residing in Québec, expenses incurred for drugs and supplies covered under Prescription drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary and not reimbursed under this plan as a result of the application of the deductible or the reimbursement percentage are limited in each calendar year to the yearly maximum contribution set by the RAMQ plan. There is an out-of-pocket maximum for you, and another one for your spouse. Expenses for drugs and supplies incurred for your children are part of the out-of-pocket maximum of the employee.
Persons age 65 or over residing in Québec	Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the public prescription drug insurance plan of the Régie de l'assurance-maladie du Québec (RAMQ), which provides basic coverage for prescription drug costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be covered by either the public plan or your group plan. If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium. On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact us to clarify your situation.

Hospital expenses in your province

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

Convalescent hospital	We will cover the cost of room and board in a convalescent hospital, as indicated in the Benefit Summary, if this care has been ordered by a doctor as long as: • it follows at least 5 consecutive days of in-patient hospitalization, • it begins within 14 days of release from the hospital, and • it is primarily for rehabilitation, and not for custodial care.
	A *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.
Hospice	We will cover the cost of room and board in a hospice, as indicated in the Benefit Summary, if this care has been ordered by a doctor. A *hospice* is a facility licensed to provide palliative and supportive care for terminally ill patients.

Expenses out of your province

Expenses out of your province	We will cover emergency services while you are outside the province where you live. We will also cover referred services. **For both emergency services and referred services, the reimbursement level is indicated in the Benefit Summary.** For both emergency services and referred services, we will cover the cost of: • a semi-private room • other hospital services provided outside of Canada • out-patient services in a hospital • the services of a doctor
Emergency services	We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged. *Emergency services* mean any reasonable medical services, drugs or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established treatment program that existed before they left their home province. *Emergency* means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. **Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away. Sun Life's ETA provider must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them.

	If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards.
	An emergency ends when Sun Life's ETA provider, based on available medical evidence, deems you medically stable to return to the province where you live.
Emergency services excluded from coverage	Any expenses related to the following emergency services are not covered: • services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services. • services relating to an illness or injury which caused the emergency, after such emergency ends. • continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or 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. However, if referred services are not available in Canada, they may be obtained outside of Canada.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private duty nurse	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties	$15,000 per person per benefit year
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	

Covered expenses	Details	Payment limits
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor, such as: general 2 complete profile, general 4 complete profile and 2-hour post-prandial (PP) blood glucose tests • ultrasounds • sleep apnea tests when prescribed by a doctor • medical imaging services, including MRI (magnetic resonance imaging), CT (computed tomography) scans, angioscans, angiograms, angiographies, enteroscans and infra-red imaging • cystoscopies • fecal immunochemical tests (FIT) • strep tests	
Dental services following an accident	Dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered You must receive these services within 6 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the employee lives
Contact lenses or intraocular lenses	After cataract surgery	One lens per eye, per lifetime
Wigs	After chemotherapy	$300 per person per benefit year
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs	For wheelchairs, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses or crutches		
Splints or braces	Must be prescribed by a doctor	
Breast prostheses	Required as a result of surgery	$200 per person per benefit year

Covered expenses	Details	Payment limits
Surgical brassieres	Required as a result of surgery	2 brassieres per person per benefit year
Artificial limbs and eyes	Must be considered conventional passive prosthetics Excludes myoelectric devices, C-legs and any other technologically advanced prosthetic device	
Stump socks		5 pairs per person per benefit year
Elastic support stockings, other than pressure gradient hose	Must be prescribed by a doctor	$50 per person per benefit year
Pressure gradient hose	Must be prescribed by a doctor	4 pairs per person per benefit year
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	
Orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair per person per benefit year
Hearing aids		$400 per person in any 24 month period Repairs are included in this maximum
Oxygen		
Insulin pumps	Must be prescribed by a doctor	
Bed rails, elevated toilet seats, shower chairs, bathtub rails and standard commodes	Must be prescribed by a doctor	
Wheelchair ramps	Must be prescribed by a doctor	$2,000 per person, per lifetime
Extremity pumps	Must be prescribed by a doctor	$1,500 per person, per lifetime
Colostomy supplies		

Gender affirmation procedures

Gender affirmation procedures	We will cover, up to the reimbursement level indicated in the Benefit Summary, the costs of the following gender affirmation procedures, provided you meet the *Eligibility requirements* set out below.

Covered expenses	Details	Payment limits
	Eligible procedures: • breast augmentation/augmentation mammoplasty. • thyroid chondroplasty. • laryngoplasty. • permanent hair removal (laser or electrolysis) for pre-surgical areas, or for excessive facial or body hair. • brow bone reduction/construction. • jaw bone reduction/reshaping/contouring. • rhinoplasty, blepharoplasty and rhytidectomy. • liposuction of the waist. • gluteal augmentation (lipofilling or implants). • hairline reconstruction to correct a receding hairline. • hysterectomy. • vaginectomy. • salpingo-oophorectomy. • chest contouring/chest masculinization, including liposuction/lipofilling done to provide additional contouring. • implantation of penile and/or testicular prostheses. • chin and cheek augmentation. • pectoral implants. 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:	

Covered expenses	Details	Payment limits
	• 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.	

Covered expenses	Details	Payment limits
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary We will not pay for the cost of services rendered by a podiatrist in Ontario or in Alberta unless they are performed after the provincial medicare plan has paid its annual maximum benefit
Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us. *Qualified* paramedical practitioners must: • belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us, • be licensed or registered, as required by the applicable provincial regulatory body, • have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered, • maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association, • produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and • not engage in administrative practices unacceptable to Sun Life. This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.		
Vision care		
Contact lenses, eyeglasses or laser eye correction surgery	An ophthalmologist or licensed optometrist must have prescribed contact lenses or eyeglasses You must have received the above from an ophthalmologist, licensed optometrist or optician We will only cover laser eye correction surgery that an ophthalmologist has performed	Up to the reimbursement level indicated in the Benefit Summary We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision

Covered expenses	Details	Payment limits
Ophthalmologist or licensed optometrist	Services of an ophthalmologist or licensed optometrist	Up to the reimbursement level indicated in the Benefit Summary

When coverage ends

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

Payments after coverage ends

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

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

If the Extended Health Care benefit ends, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if both of the following apply:

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

What is not covered

We will not pay for the costs of:

- services, drugs or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services, drugs or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- services, drugs or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services, drugs 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, active duty or training in the armed forces during a military leave for reservists, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

Integrating this plan with government programs

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

The covered expense under your employer's plan is the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

Emergency Travel Assistance

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.

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

The emergency services excluded from coverage, and all other conditions including maximums, limitations and exclusions that apply to your Extended Health Care coverage also apply to Medi-Passport.

Bring your Travel card with you! There you will find telephone numbers and the information you'll need to confirm your coverage and get help.

Getting help	**Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away.
	If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card. 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 (sent home); or • **for a child** if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified person to go home with the child as their attendant. We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.
Travel expenses of family members	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 hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.

Returning you home (repatriation)	If you die while out of the province where you live, Sun Life's ETA provider will pay up to $5,000 to do the following: • arrange for all necessary government authorizations. • arrange for the return of your remains in an approved container.
Returning your vehicle	Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 to return a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from doing so.
Lost luggage or documents	If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Sun Life's ETA provider will direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
Limits on advances	Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.
Reimbursement of expenses	If you obtain confirmation from Sun Life's ETA provider that you are covered and a medical emergency exists, Sun Life will reimburse you for services, drugs and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Sun Life's ETA provider. Sun Life's ETA provider's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-800-361-6212. Sun Life's ETA provider will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Sun Life's ETA provider before your claim can be processed.
Coordination of coverage	If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.
Your responsibility for advances	You will have to reimburse Sun Life for any of the following amounts advanced by 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, drugs or supplies not covered by this plan. • amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you. Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received.

Limits on Emergency Travel Assistance coverage	There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before you leave on your trip.
	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, terrorism 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

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 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 and customary 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 fee guide may also mean an adjusted fee guide established by Sun Life.

Reasonable and customary charges mean*:*

- charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined by Sun Life.

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

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

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

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

For an implant related crown or prosthesis	We will pay the benefit that would have been payable under this plan for a tooth supported crown or a non-implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. **All other expenses related to implants, including surgery charges, are not covered.**
If you receive any temporary dental service	It will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the reasonable and customary charge for the final dental service.
Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incurred the expense. The benefit year is indicated in the Benefit Summary. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed, except for orthodontic procedures where an expense is incurred for each appointment. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Deductible and reimbursement level	The deductible is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the deductible and the reimbursement level are indicated in the Benefit Summary**.
Maximums	Maximums are indicated in the Benefit Summary.
Getting an estimate before you have certain procedures	For any major treatment or any procedure that will cost more than $500, we suggest that you send us an estimate before the work is done. Here's what to expect: • you will send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. • both you and the dentist will have to complete parts of the claim form. • we will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Your dental services at a glance

Covered expenses	Details / Payment limits
Preventive dental procedures – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.	
Oral examinations	• 1 complete examination or 1 recall examination every 5 months, up to a combined 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 2 sets per benefit year. • x-rays to diagnose a symptom or examine progress of a certain course of treatment. • sialography.
Other services	• required consultations between two dentists. • polishing (cleaning of teeth) and topical fluoride treatment once every 5 months, up to 2 per benefit year. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth and related anaesthesia. • providing space maintainers for missing primary teeth. • habit breaking appliances. • pit and fissure sealants. • use of radiopaque dyes to demonstrate lesions. • scaling and root planing, up to a combined maximum of 2 units of 15 minutes per benefit year for a child under age 13 or 10 units of 15 minutes per benefit year for any other person.

Covered expenses	Details / Payment limits
	• personal protective equipment (PPE), when submitted with an eligible dental expense.
Basic dental procedures – Your dental benefits include the following procedures used to treat basic dental problems.	
Fillings	• amalgam (silver) and composite or acrylic (white), or equivalent.
Extraction of teeth	• removing teeth, except impacted teeth (*Preventive dental procedures*).
Basic restorations	• prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.
Endodontics	• root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.
Periodontics	• treating disease of the gum and other supporting tissue, other than scaling and root planing (*Preventive dental procedures*).
Oral surgery	• surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*). • treatment of fractures. • prosthetic stents. • reconstruction of the alveolar ridge.
Major dental procedures – Your dental benefits include the following procedures used to treat major dental problems.	
Major restorations	• inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*). Replacements must be separated by at least 5 years.
Repair of bridges	• repair of bridges.
Repair of dentures	• repair of dentures.
Rebase or reline	• rebase or reline of an existing partial or complete denture.
Prosthodontics	Construct and insert bridges or standard dentures. We do not consider charges for a replacement bridge or replacement standard denture an eligible expense during the 5 year period after a previous bridge or standard denture is constructed or inserted**, unless either 1. or 2. below is true:** 1. it is needed to replace a bridge or standard denture which has caused temporomandibular joint (TMJ) disturbances and which cannot be economically modified to correct the condition. 2. it is needed to replace a transitional denture which was inserted shortly after teeth were extracted, where the dentist cannot economically get it to the final shape needed.

Covered expenses	Details / Payment limits
Orthodontic procedures – Your dental benefits include the following procedures used to treat misaligned or crooked teeth. **Only persons under the maximum age indicated in the Benefit Summary are covered for these procedures.**	
Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces	The following orthodontic procedures are covered: • interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*). • comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

When coverage ends

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

Payments after coverage ends

If the Dental Care benefit terminates, we will still cover you for procedures to repair natural teeth damaged by an accidental blow:

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

If your coverage terminates under this plan for any reason other than the termination of this plan or this Dental Care benefit, and supplies required for a dental treatment were ordered prior to the termination of coverage or treatment had begun prior to the termination of coverage, you will continue to be covered for expenses related to such treatment provided these expenses are incurred within 30 days after the termination of your coverage.

What is not covered

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

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

We will not pay for:

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

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, active duty or training in the armed forces during a military leave for reservists, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.
- participation in a criminal offence.

Personal Spending Account

Administrator

This Personal Spending Account is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has established a Personal Spending Account and has the sole legal and financial liability for this Personal Spending Account under the Personal Spending Account Services Contract entered into with Sun Life. Sun Life only acts as administrator.

Your employer will be responsible for all payroll related deductions and issuing the appropriate tax information slips related to your Personal Spending Account.

Your Personal Spending Account coverage provides reimbursement to you for expenses described in this section under *Eligible expenses*.

An expense is incurred on the date the expense is billed. Eligible expenses incurred by your dependent are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Personal Spending Account and before the date the Personal Spending Account ends.

Your dependent must be your spouse or your children and any other member of your family or your spouse's family who are dependent on you for financial support, such as parents, grandparents or grandchildren, and a resident of Canada or the United States. However, for medical and dental expenses covered under the Extended Health Care, Dental Care and Health Spending Account benefits, your children or your spouse’s children do not have to be dependent on you for financial support to be considered a dependent. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care or Dental Care benefits.

The benefit year is indicated in the Benefit Summary.

How your Personal Spending Account works	Your Personal Spending Account works like an expense account. Your employer will allocate credits to your Personal Spending Account in the manner described under *Credits* in the Benefit Summary. Each time you submit a Personal Spending Account claim, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Personal Spending Account.
Balance carry-forward	This Personal Spending Account is set up with a ***balance carry-forward*** feature. This means that you may be reimbursed for eligible expenses incurred in a benefit year using credits received during that benefit year, as well as any unused credits that have been carried forward from the previous benefit year. In other words, any credits remaining in your Personal Spending Account at the end of one benefit year will be carried forward and may be used to reimburse you for eligible expenses incurred in the following benefit year. Credits that are carried forward from one benefit year to the next will be lost at the end of the second benefit year if you have not used them by then. Carried forward credits are always used before new credits are used. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Eligible expenses

You can use your Personal Spending Account to help you pay for the following eligible expenses:

Fitness-related services

- fitness club memberships.
- registration fees for virtual fitness classes.
- registration fees for fitness-related programs or lessons, such as aerobic classes, yoga, dance lessons and figure skating.
- sports team memberships and registration fees.
- annual memberships, such as golf.
- court fees, green fees, ski passes, lift tickets and race registrations.
- personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.
- recreational activity fees (such as boating fees, camping fees and trail passes).
- fitness-related apps, software and programs.
- hunting and fishing licenses.

Fitness equipment

- durable equipment such as treadmills, exercise bikes and universal gym.
- skates, roller blades, bicycles, specialized athletic footwear, tennis racquets, golf clubs, safety helmets and specialized sports equipment.

Health-related services

- weight management programs (excluding food).
- smoking cessation programs.
- nutrition programs and counselling.
- maternity services (prenatal classes and mid-wife services).
- services of the following alternative health practitioners: reflexologist, iridologist, herbalist, homeopath, athletic therapist, Chinese medical practitioner, Shiatsu therapist, osteopathic practitioner and acupressurist.
- stress management programs.
- cholesterol and hypertension screening.
- first aid and CPR (cardiopulmonary resuscitation) training.
- health assessments.
- allergy tests.
- vitamins and supplements, including herbal products.
- other alternative wellness services: Reiki, Ayurvedic medicine, touch therapy, Rolfing and light therapy.
- cosmetic dentistry.
- medical alert products and services.
- life coach services or fees for spiritual or wellness retreats (excludes the cost of travel and accommodations).
- health-related apps, software and programs.

Work-life balance

- child care expenses.
- elder care expenses (medical and dental expenses for a parent who needs medical support including care, treatment or surgery done in a private clinic).

Professional services

- services of professionals for estate planning, financial counselling, tax return preparation and will preparation.

When coverage ends

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

Surviving dependent coverage

The Personal Spending Account is set up under the employee's name, and there is no continuation of coverage for dependents after the employee's death. Only eligible expenses incurred before the employee's death can be reimbursed under the employee's Personal Spending Account.

Short-Term Disability

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 confirms both of the following:

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

For the purposes of your Short-Term Disability coverage, we will consider you to be totally disabled while you are continuously unable due to an illness to perform the essential duties of your own job. The availability of work with any employer does not affect the determination of total disability.

In addition, if you are prevented from being actively at work due to a safety critical disability (as defined by the Railway Safety Act) or a safety sensitive disability (as defined by your employer), you will be considered totally disabled.

We will base your benefits on your coverage on the date you became totally disabled. We pay benefits at the end of each week for which you are entitled to payments.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

When disability payments begin	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. If benefits are payable for part of any week, we will pay 1/7 of the weekly benefit for each day you are entitled to a payment.
What we will pay	Here is how we calculate your Short-Term Disability payments. All references to benefits and payments in this disability provision are to the gross amounts before any deductions. **Step 1: We take the maximum amount indicated in the Benefit Summary.** If your Short-Term Disability benefit is less than the benefit that would be payable under the Employment Insurance Act, your basic earnings will be increased by the amount of bonus, commission, overtime or incentive pay earned on a regular basis, required to calculate the amount of benefit payable under the Employment Insurance Act. **Step 2:** (a) **During the entire period of total disability**, we subtract any benefits or payments provided: • under a motor vehicle insurance plan. • under a group plan which provides income replacement benefits as a result of an accident or an illness, including a multiple-employer group plan but excluding any benefits or payments provided under a Critical Illness plan or an association plan.

- as part of a salary continuance received from your employer during your disability.
- under Employment Insurance (after the first 15 weeks of total disability only).
- 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 benefits or payments provided:

- under any government-sponsored plan such as the Canada Pension Plan and the Québec Pension Plan*, excluding all benefits or payments on behalf of a dependent, in connection with the same or a subsequent disability.
- under a retirement or pension plan funded in whole or in part by your employer, due to your disability or a medical condition.
- under any coverage resulting from your membership in an association but excluding any benefits or payments provided under a Critical Illness plan.

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

However, if the amount calculated under Step 2, plus:

- **during the first 17 weeks of total disability** – the sources of benefits and payments listed in (a) above is more than 100% of your basic earnings when your disability began, we will reduce your Short-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.
- **after the first 17 weeks of total disability** – the sources of benefits and payments listed in (a) and (b) above is more than 100% of your basic earnings when your disability began, we will reduce your Short-Term Disability payment by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

Important to remember:

- *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.
- There are times when we will estimate the amount of the benefits or payments you are entitled to and deduct the estimated amount from your weekly disability benefit. Refer to your group contract for more information.
- If any of the benefits or payments described above are provided in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.
- We will not take into account any benefits or payments that began before your disability began. However, increases in those benefits or payments as a result of your disability will be taken into account.
- We have the right to adjust your Short-Term Disability benefit payments when appropriate under the above provision.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability reoccurs due to the same or related causes, we will consider it a continuation of your previous total disability as long as the disability reoccurs within 4 weeks of the end of your previous disability.

We will base these benefits on your coverage as it existed on the original date of total disability and will pay them for no longer than the rest of the maximum benefit period.

Rehabilitation program

Sun Life may require you to participate in a rehabilitation program that we have approved in writing.

This may include one or more of the following:

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

During your rehabilitation program, you may receive Short-Term Disability payments plus income, benefits and payments from other sources.

However, the Short-Term Disability payments will be reduced by 50% of the income you receive under the rehabilitation program. If during any week the total of any income, benefits and payments provided is more than 100% of your basic earnings when your disability began, your Short-Term Disability payment will be reduced by the excess. If the benefit is non-taxable, your income after income tax is the one we use.

If you recover damages from another person

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

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

For disability benefits paid or payable prior to the date of judgment or settlement, if you recover money, you must pay us 75% of your net recovery or the total disability benefits paid or payable to you under this plan, whichever is less. For disability benefits payable after a judgment or settlement, where 75% of your net recovery exceeds the amount that we recover for past disability benefits, we have the right to deduct that excess from ongoing disability benefits. Refer to your group contract for more information.

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 the maximum benefit period indicated in the Benefit Summary.
- the date you retire on pension.
- the date you die.

When coverage ends

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

What is not covered

We will not pay benefits for any period where one or more of the following is true:

- you are not receiving appropriate treatment.
- you do any work for wage or profit except where Sun Life has approved it in advance.
- you are not participating in an approved rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off. 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 benefits for total disability resulting from:

- the hostile action of any armed forces, active duty or training in the armed forces during a military leave for reservists, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

Life Coverage

Insurer

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

General description of the coverage

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

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Who we will pay	If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life. If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. **Fact** If you designated a beneficiary under a previous group plan of the employer, Sun Life will apply and carry it forward to your coverage under this plan until you change it. There are different rules for designating a minor beneficiary, please refer to your contract for specific information.
Coverage during total disability	Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 65, whichever is earlier, as long as you are totally disabled. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations. There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact Sun Life for details.

What is not covered

For reservists on military leave, we will not pay benefits if your death is caused by your active duty or training in the armed forces.

Converting Life coverage

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

The request must be made within 31 days that the Life coverage reduces or ends.

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

Basic Accidental Death & Dismemberment

Insurer

This benefit is insured by AIG Insurance Company of Canada.

Policy No.: GPA 9109375

Why You Should Have Accident Insurance

A serious accidental Injury or death can have tremendous consequences for your family that may prevent you or your Spouse from meeting your financial obligations. Your Employer has provided you with accident insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to your beneficiary to help ease any financial burden if you suffer a Loss of Life as a result of an accident. The policy also provides you with 'living benefits' should you suffer an accident that results in any of the Losses listed in the Table of Losses, such as Paralysis or Loss of Hearing.

Eligibility and Principal Sum

Your plan provides Accidental Death & Dismemberment benefits for Injuries as a result of covered accidents. You are automatically covered for a Principal Sum amount of $50,000, if you are an active full-time TCRC unionized employee of VIA Rail Canada Inc., who is insured under the VIA Rail Canada Inc's Basic Group Life insurance policy.

Definitions

The following is an explanation of commonly used terms in this benefit booklet. For the full list of definitions refer to the policy.

Annual Earnings means your annual salary from employment with your Employer immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

Company means AIG Insurance Company of Canada.

Dependent Child means a person who is either your natural child, adopted child or step-child or a child to whom you are in loco parentis and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

Employer means the Policyholder or an affiliate or subsidiary thereof, for which you are employed.

Hospital means an establishment which:

(a) holds a license as a hospital (if licensing 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 licensed 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 means a person who is related to you 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*** means bodily injury which is sustained by you as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while your insurance under this policy is in force.

Insured Employee means 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.

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 severance through or above the wrist or ankle joint, but below the elbow or knee joint;

(c) ***Arm or Leg*** means the complete severance through or above the elbow or knee joint;

(d) ***Thumb and Index Finger*** means the complete severance through or above the first phalange;

(e) ***Fingers*** means the complete severance through or above the first phalange of all four Fingers of one Hand;

(f) ***Toes*** means the complete 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.***

Physician means a medical doctor, other than you or your 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.

Private Passenger Type Automobile means 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 means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you, and is publicly represented as

your domestic partner in the community in which you reside.

General Policy Provisions

Effective Date

Your coverage begins on the date you satisfy the eligibility requirements to become an Insured Employee.

Termination Date

Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee;
4. the date the Termination of Coverage is met as set out in the Policy Schedule; or
5. the first day of the month following the date you no longer belong to an eligible class of employees as set out in the policy.

Continuance of Coverage

If you are no longer employed or actively working, your coverage shall continue 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, provided premiums continue to be paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage to an individual insurance policy that provides comparable coverage. The amount of insurance benefit provided for the new policy shall not exceed the lesser of $500,000 or your Principal Sum in force at the time you convert your policy. The premium due will be based on the rates in force for individual policies at time of application.

Aggregate Limit Per Accident

The maximum amount the Company will pay for two or more Insured Employees injured in one accident is the amount of the Aggregate Limit Per Accident set out in the policy schedule, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Employee shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered Loss occurs within 365 days after the date of the accident causing the Loss, the Company will pay the indicated percentage of the Principal Sum as set out in the following Table of Losses. If you sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

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%
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

Additional Benefits

These benefits shall only apply if selected by your Employer and the appropriate premium paid. The Benefit Description is a summary only and does not include all of the provisions, sub-limits, conditions and exclusions.

Benefit	Maximum	Benefit Description
DISAPPEARANCE	Principal Sum	Pays the Loss of Life Principal Sum if your body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant.
REHABILITATION BENEFIT	$15,000	Pays the expenses incurred for occupational training up to the Maximum if such expenses are incurred within three years of the accident and are as a result of an Injury for which you receive a benefit under the policy.
HOME ALTERATION AND VEHICLE MODIFICATION	$15,000	Pays a one-time benefit up to the Maximum for covered home alternation and vehicle modification expenses if you suffer an Injury for which you receive a benefit under the policy and require a wheelchair to be ambulatory.
WORKPLACE MODIFICATION AND ACCOMMODATION	$5,000	Pays a one-time benefit to your Employer up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require special adaptive equipment or workplace modification in order for you to return to work full-time for the Policyholder.
PSYCHOLOGICAL THERAPY	$5,000	Pays a benefit up to the Maximum if you suffer an Injury for which you receive a benefit under the policy and require psychological therapy within two years of the Injury.
IN-HOSPTIAL BENEFIT	$2,500/month	Pays a benefit of (i) 1% of the Principal Sum up to the Maximum for hospital confinements of more than 30 nights, or (ii) 1/30th of the amount determined under (i) for hospital confinements of more than five but less than 30 nights, if you suffer an Injury for which you receive a benefit under the policy and are confined to hospital as a result of such Injury, for a maximum of twelve months.
FAMILY TRANSPORATION	$15,000	Pays a benefit up to the Maximum for the expenses incurred for the transportation of an Immediate Family member to your hospital if you suffer an Injury for which you receive a benefit under the policy and as a result are confined to a hospital more than 100 kilometres from home.
REPATRIATION BENEFIT	$15,000	Pays a benefit up to the Maximum to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.
IDENTIFICATION BENEFIT	$5,000	Pays a benefit up to the Maximum for the transportation and commercial lodging of an Immediate Family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.
DAY CARE BENEFIT	$5,000/year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.
DEPENDENT CHILD EDUCATIONAL BENEFIT	$5,000/school year	Pays an annual benefit of up to 5% of the Principal Sum up to the Maximum for the tuition costs of each Dependent Child who is enrolled as a full-time student in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

SPOUSAL EDUCATIONAL BENEFIT	$15,000	Pays a benefit up to the Maximum for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 36 months of your death.

Benefit	Maximum	Benefit Description
FUNERAL EXPENSE	$5,000	Pays a benefit up to the Maximum to reimburse funeral expenses if you suffer a covered accidental death.
BEREAVEMENT BENEFIT	$1,000	Pays up to the Maximum if you suffer loss of life in a covered accident and your eligible dependents require counselling within one year of your loss of life.
SEAT BELT AND AIR BAG BENEFIT	$50,000	Pays an additional benefit of 10% of the Principal Sum up to the Maximum if you suffer a covered accidental death while operating or riding as a passenger in a Private Passenger Type Automobile in which your seatbelt was properly fastened. If the seat belt benefit is payable and you were in a seat protected by a properly functioning supplemental restraint system which inflated on impact, an additional benefit of 10% of the Principal Sum will be paid. The Seat Belt and Air Bag Benefit is payable up to the Maximum combined.

Policy Exclusions

The policy will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat;

(b) self inflicted Injury or any attempt thereat;

(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 you are 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 you are:

  (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

  (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 aircraft owned, leased or chartered by the Policyholder;

(h) travel or flight in or on (including getting in or out of, or on or off of) any aircraft or 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 if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority;

(k) Injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;

(l) Injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed Physician;

(m) the commission or attempted commission by you or Injury incurred while you are 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; and

(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and

(o) natural causes.

Claims Process

Beneficiary Designation

You have the option to designate a beneficiary. Should you choose not to, in the event of accidental Loss of Life, the benefit will be paid to the beneficiary you have designated in writing under your Employer's basic group life policy. If there is no written designation validly made for the purposes of the Employer's current basic group life insurance policy, then the benefit will be paid to your estate.

All other benefits will be payable to you.

How to Make a Claim

In the event of claim, claim forms can be obtained from your Employer.

Written notice of claim to the Company must be given no later than 30 days from the date of accident. Within 90 days from the date of the accident, proof of claim must be submitted to the Company. Proof may include 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 legally qualified medical practitioner.

Failure to give notice of claim or furnish proof of claim within the time prescribed above 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.

Important Notes

This booklet, as may be amended, provides only a summary of the provisions for the Group Personal Accident coverage and the Additional Benefits. The full coverage details are contained in the policy including eligibility, limitations, exclusions and termination provisions. In the event of a discrepancy between this booklet and policy, the terms of the policy shall govern.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations. Possession of this booklet alone does not mean that you or your dependents are covered. The policy must be in effect and you must satisfy all the requirements.

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

Insurance is underwritten by AIG Insurance Company of Canada.

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).

Life’s brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
a member of the Sun Life Financial group of companies.

GB10171-E

Sun Life Financial