



Shared Services Branch

AMSC Benefits Services

Group Benefits Booklet

Lac La Biche County

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Benefits Plan Summary

This Benefit Plan Summary contains a general description of your benefit plan and applicable rates. Please refer to benefit plan descriptions for more detailed information on each benefit.

Elected Officials are NOT eligible to participate in the Short or Long Term Disability plans.

Seasonal Employees are NOT eligible to participate in Short or Long Term Disability or Optional Life plans.

Your employee benefit coverage is as follows:

Eligibility (Waiting Period)

If you are in an eligible class of employees, you are eligible for benefit coverage:

Regular Employees - following three (3) months of employment.

Management – upon date of hire.

Elected Official – you must enrol in the Benefits Program within 60 days of being elected to office.

Failure to enrol in the Benefits Program immediately following completion of the waiting period will subject you to Late Entrant (medical evidence of insurability) requirements.

Basic Group Life

Regular Employees and Management - Two (2) times annual earnings rounded upwards to the next highest thousand, if not already an even thousand. Your coverage amount will be adjusted as your salary changes. The minimum coverage amount is \$10,000 and the maximum \$500,000.

Elected Officials - \$30,000 or two (2) times annual salary, whichever is the greater, as selected by your employer.

Accidental Death & Dismemberment

The principal amount of insurance will match your Basic Group Life coverage amount. Details of coverage, including a schedule of losses, are provided in your benefit plan description.

Dependent Life

Spouse	\$10,000
Dependent Child(ren)*	\$ 5,000

*Birth to 21 years (to age 25 if a full-time student)

Long Term Disability

Elimination Period:	120 calendar days
Own Occupation Period:	Two (2) years
Monthly Benefit::	75% of monthly pre-disability earnings
Maximum Benefit Period:	To age 65, recovery or death, whichever occurs first
Maximum Monthly Benefit::	\$6,000
Benefit Tax Status:	Taxable

Best Doctors

Best Doctors[®] is a new program that is offered to those who qualify for Short or Long Term Disability. This program provides medical information and expert advice to help you answer your medical questions.

Extended Health Care

Extended Health Care benefits provide coverage at 100% reimbursement for prescription drugs and 100% reimbursement for all other reasonable and customary eligible expenses.

Your group participates in the Shared Health Network pay direct system (drug card) for prescription drugs. Eligible expenses for other eligible health services and medical devices are paid by the insurance company on a reimbursement basis.

Vision Care

Your Vision Care plan provides a \$500 Vision Care benefit.

Dental Care

Basic and Diagnostic:	100% Reimbursement	}	\$1,500 Combined Maximum
Dentures:	100% Reimbursement		
Major Restorative:	80% Reimbursement	}	\$1,500 Lifetime Maximum
Orthodontics:	50% Reimbursement		

The benefit calendar year maximum is \$1,500* per insured person for all coverage's combined excluding Orthodontics for which there is a \$1,500 lifetime maximum.

****Employees whose insurance becomes effective on or after July 1st of any year will be limited to \$750 per insured for the balance of the calendar year.***

Employee Assistance Program (EAP)

This program is a voluntary confidential counselling and referral service for you and your immediate family members. There is no cost to you for using the program.

Health Care Spending Account

For Regular Municipal Employees, Health Care Spending Account credits of \$750 will be provided by the Employer at the commencement of each Benefit year.

Guaranteed Critical Illness

New employees and their spouse qualify for \$10,000 of voluntary guaranteed critical illness insurance with no medical evidence if they apply within 90 days after satisfying their benefit waiting period. The insurance company for this insurance is Industrial Alliance Pacific, contract number 100003919.

Optional Critical Illness

Optional Critical Illness Insurance is available through your benefits plan. Employees and their spouse can each apply for Optional Critical Illness insurance in units of \$25,000 to a maximum of 12 units for a total of \$300,000. Regular application procedures apply, medical evidence is required. The insurance company for this insurance is Industrial Alliance Pacific, contract number 100003919.

Optional Life/Spousal Optional Life

Optional Life and Spousal Optional Life Insurance coverage may be applied for. See your Benefits Administrator for details and/or application forms.

Retiree Benefits Package

Upon retirement (minimum age 55), you can apply for an individual retiree benefits package which includes life, health and dental for you and your dependents. AMSC Insurance bills you directly. The plan terminates at age 70. See your Benefits Administrator for details.

Introduction and Eligibility

The benefits and levels of coverage are outlined in the Benefits Plan Summary listed at the beginning of this booklet for your convenience.

The information provided has been designed to give you a general description of your group insurance. If after reading the brochures you have specific questions regarding coverage, you should contact your Benefits Plan Administrator. If your questions cannot be answered by your Benefits Administrator please contact the AMSC Insurance office at 310-2862 (toll-free number for both long distance and local calls).

Note: *The enclosed information is a summary only and does not create or confer any rights. The terms of the master policy between AMSC Insurance Ltd. and the insurer will govern administration and payment of benefits under the contract. This is an important document and should be kept in a safe place.*

Note: *The eligibility requirements shown in this section are the minimum required in the program. Your employer's provisions may differ.*

Eligible Employee Classes

Permanent Full-time/Permanent Part-time Employees

Employees of participating municipalities and employees of other organizations which are full or associate members of AUMA, who work a minimum of 15 hours per week, are eligible to participate in all benefits offered by their employer with the exception of Long Term Disability. A minimum of 20 hours per week must be worked in order to participate in the LTD Plan.

Returning Seasonal Employees

Returning seasonal municipal employees and returning seasonal associated municipal employees who work a minimum of 25 hours per week and who are employed for a minimum of seven months of the year are eligible to participate in all benefits offered by their employer with the exception of Short and Long Term Disability. Returning seasonal employees who work a minimum of 25 hours per week and who work seven months consecutively per season may participate in Short and Long Term Disability plans if the employer offers these benefits to this class of employee.

Elected Officials

Elected officials of a participating municipality are eligible to participate in all benefits offered to the municipality with the exception of Short and Long Term Disability coverage. Short and Long Term Disability coverage is only available to this class of employee should it be specifically identified in the Benefit Plan Summary.

Volunteer Firefighters and Ambulance Personnel

Volunteer firefighters and volunteer ambulance personnel who perform such duties for a participating municipality may be eligible to participate in Group Life Insurance, Accidental Death and Dismemberment and Dependent Life Insurance.

Eligible Dependents

The term “**Dependent**” means your spouse and/or dependent children who:

- reside in Canada or in the case of a dependent child who is a fulltime student.
- are not members on active duty of the armed forces of any country.

The term “**Dependent Spouse**” means the spouse of the insured employee who is either:

- a person legally married to the insured employee;
- a person, regardless of gender, who is not legally married to, but has resided continuously with the insured employee for a period of at least 12 months and who is represented publicly as the spouse, provided that a written request for spousal coverage is made by the insured employee. See your Benefits Administrator for further information.

The term “**Dependent Child**” means an unmarried child, stepchild, foster child, legally adopted or legal ward either:

- of the insured employee or the legal spouse, who may or may not reside with them but is fully dependent on them for support;
- of the insured employee or the common-law spouse, who is in the care and custody of both, residing with them and being fully dependent on them for support; and
- is within the following age brackets unless otherwise shown by the Benefits Plan Summary of the participating municipality:
 - Dependent Life: birth to 21 years
 - All other Coverage: birth to 21 years
 - Fulltime Students: 21 years to 25 years, for all benefits with the exception of Orthodontic services provided under Dental Care. Students studying outside Canada must apply in advance of leaving Canada for continuation of all or some benefits.
 - Handicapped Child: There is no upper age limit so long as the child remains fully dependent on the employee for support by reason of a mental or physical handicap with the exception of Orthodontic services under Dental Care.

Effective Dates

Employees

Coverage becomes effective on the date you become eligible providing that you are actively at work on that day. If you are not actively at work on the day your group insurance coverage would normally commence, you will be eligible on the date you return to work. The date on which you become eligible for benefit coverage is determined by the waiting period chosen by your employer. This is shown on the Benefits Plan Summary.

Dependents

Coverage for dependents you have when you join the plan is coincident with your effective date. If those dependents are hospitalized at time of initial participation, with the exception of a new born for purposes of Extended Health Care only, hospitalized dependents will be considered eligible upon release from hospital. Group insurance plan coverage for dependents you acquire after you join the plan is effective on the date you acquire them with the exception of a common-law spouse which is subject to a twelve-month cohabitation provision.

Evidence of Insurability

Medical evidence of insurability is not required if you enrol in the Benefits Program within 31 days after completion of the prescribed waiting period. Please refer to the Benefits Plan Summary. The exception to this is Optional Life which requires medical evidence of insurability. The insurance is effective on the date the insurance company approves it.

Late Entrant/Medical Evidence of Insurability Provisions

Medical evidence of insurability for you and your dependents is required if:

- Coverage is applied for after 31 days of becoming eligible;
- Coverage is applied for after 31 days of losing coverage under a spouse’s plan;
- Dependent coverage is applied for more than 31 days after dependents have been acquired.

When medical evidence of insurability is required, coverage is not effective until your Benefits Administrator receives notice of approval from the insurer. Coverage can be denied based on medical evidence and it should be noted that the health condition does not have to be life threatening to disqualify you and/or your dependents.

Dental Late Entrant

If you are a Late Entrant for Dental coverage your Benefits Administrator may add you for coverage; however, you will be limited to \$300 per person during the first 36 months for Orthodontic procedures and \$100 of benefit per person for the first 12 months of coverage for all other expenses.

Termination of Employment or Retirement Prior to Age 65

Benefits cease on the date of termination of employment/retirement with the exception of Basic Group Life Insurance which is effective for 31 days after termination. Retiree Life Insurance may be available. Please refer to the Benefits Plan Summary.

Active Employees Beyond the Age of 65 Years

If you continue employment with your employer beyond age 65, benefits available to you are as follows:

- **Basic Group Life** - Full coverage to age 70, beyond age 70 Basic Group Life will reduce to 10% of coverage held prior to age 70. Elected Officials coverage reduces to \$15,000.
- **Accidental Death and Dismemberment** – Coverage can continue to age 70 as long as you remain employed and premiums are paid.
- **Dependent Life** – Coverage can continue to age 70 as long as you remain employed and premiums are paid.
- **Optional Life** – Coverage ceases at age 70.
- **Long Term Disability** - Coverage ceases 120 days prior to age 65.
- **Extended Health and Dental Care** – Coverage can continue, however, extended health benefits will be coordinated between the Alberta Seniors Benefit program coverage and they will be the first payers. The balance of eligible claims can be paid for by this plan.
- **Critical Illness** - Coverage terminates at age 75.

The total benefits from all plans will not exceed the eligible expenses incurred.

Basic Group Life

Regular Employees - Two (2) times annual earnings rounded upwards to the next highest thousand, if not already an even thousand. Your coverage amount will be adjusted as your salary changes. The minimum coverage amount is \$10,000 and the maximum \$500,000.

Elected Officials - \$30,000 or Two (2) times annual salary, whichever is greater, as selected by your employer.

Benefit

If you die from any cause while insured, your beneficiary will receive the basic group life amount in effect on the date of your death. This amount is a multiple of your annual salary. The multiple is shown in the Benefits Plan Summary.

As Basic Group Life coverage is determined by annual salary; salary changes will affect your coverage amount. Coverage reduces to 10 percent of principal sum at age 70 for employees.

Coverage reduces to a flat \$15,000 at age 70 for elected officials.

Your Basic Group Life Insurance is term insurance and has no cash value, pays no dividends and cannot be used to secure a loan.

Beneficiary

Your beneficiary is as designated on your Enrolment Form. Should you wish to change your named beneficiary please advise your Benefits Plan Administrator.

You may name any person or persons, estate or institution (except your employer) as your beneficiary. If naming a beneficiary under age 18 years please see your Benefits Administrator for details.

Proof of Claim

If a person dies, proof of claim should be made as soon as possible after the death occurred.

Waiver of Premium

If you are disabled prior to age 65 and you remain disabled for a period of at least 4 months, your Basic Group Life Insurance premiums may be waived and your pre-disability life coverage will remain intact for as long as you remain totally disabled prior to your 65th birthday. The insurance company will automatically advise you and your employer of this provision if you participate in the Long Term Disability plan, and if you are approved for the waiver of premium. If, however, you are not a participant of the Long Term Disability plan, you must submit an application to have your Basic Group Life Insurance premiums waived. Your Benefits Administrator will provide assistance.

Waiver of premium terminates on the earliest of:

- the date you cease to be totally disabled;
- the date you fail to provide the insurance company with satisfactory proof of continuous total disability;
- the date you refuse a medical examination by a physician chosen by the insurance company;
- the date you attain age 65.

Termination of Coverage

Basic Group Life coverage terminates on the earliest of:

- termination of your Basic Group Life coverage;

- termination of your eligibility for Basic Group Life Insurance for any other reason.

Conversion Privilege

If part or all of your insurance under this benefit terminates because your employment terminates or your classification changes to one which is not eligible for insurance under this policy, you can convert up to the full amount of your terminated Basic Group Life Insurance to an individual policy.

The individual policy will be issued without evidence of insurability being required subject to the following terms:

- the employee must make written application and pay the first premium within 31 days after the insurance under this group benefit terminates;
- the individual policy becomes effective on the 32nd day after group benefits terminate;
- the individual policy cannot be less than the current minimum which the insurance company issues unless it is for the total amount which the employee may convert, nor can it be more than the amount of insurance which is convertible (i.e. your pre-termination coverage).

How to Claim

Your Benefits Administrator or your Human Resources Department will provide the claim forms and any assistance required to prepare the claim.

Accidental Death & Dismemberment

The principal amount of insurance will match your Basic Group Life coverage amount.

Benefit

If you die as a result of an accident while you are insured, the Accidental Death and Dismemberment plan will pay an amount equal to your Basic Group Life Insurance (Principal Sum) benefit as shown in the Benefits Plan Summary.

Accidental Death and Dismemberment benefits will be paid according to the following schedule:

For Loss of:	Amount Payable (% of Principal Sum)
Life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	75%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33 1/3%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four toes on the same foot	25%
Loss of use of both arms or both legs	100%
Loss of use of both hands or both feet	100%
Loss of use of one arm or one leg	75%
Loss of use of one hand or one foot	75%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

Repatriation Benefit

When bodily injuries covered by this benefit are sustained 100 or more kilometres from your normal place of residence and result in loss of life (within 365 days after the date of the accident), the insurance company will pay your estate up to \$10,000 for the actual expenses incurred for preparing and shipping your body to the place of burial.

Child Education Benefit

Should you die accidentally, up to 5% of the Principal Sum (maximum \$5,000) in each of four consecutive years is available to cover post-secondary education expenses for one dependent child.

Beneficiary

In the event of your accidental death, your beneficiary for this benefit will be the same as your Basic Group Life beneficiary. Dismemberment or Loss of Use claims will be paid to you.

Proof of Claim

If a person dies, proof of claim should be made as soon as possible after the death occurred.

If a person suffers a loss other than death, proof of claim must be received by Sun Life within one year of the loss.

Waiver of Premium

If you become totally disabled prior to age 65 and your Basic Group Life Insurance premiums are waived, your Accidental Death and Dismemberment Insurance premiums will also be waived for as long as this Accidental Death and Dismemberment plan remains in force and you remain totally disabled, but not beyond your 65th birthday.

Termination of Coverage

Accidental Death and Dismemberment coverage terminates on the earliest of:

- your 70th birthday;
- termination of your Basic Group Life coverage;
- termination of your eligibility for Accidental Death and Dismemberment Insurance for any other reason.

Rehabilitation Benefit

In the event you sustain any injury which results in the payment of benefits under the loss schedule and rehabilitation is necessary to regain employment in another occupation, up to \$10,000 is payable for necessary expenses (excluding ordinary living and travel costs) incurred within three years from the accident.

Spouse Occupational Training Benefit

Should you die accidentally and a death benefit becomes payable under this plan, certain expenses for your spouse's occupational re-training can be paid. Up to \$5,000 is available for related expenses (excluding ordinary living and travel costs) incurred within three years of the date of death.

Family Transportation Benefit

If you are hospitalized more than 150 kilometres from home as a result of an accidental injury which would result in the payment of a benefit under the plan's loss schedule, reasonable expenses for the accommodation (excluding board) and transportation of immediate family are payable. Up to \$5,000 for any one accident is available.

Exclusions and Limitations

This benefit does not cover any claim arising out of bodily injury or death caused or contributed by:

- Self-inflicted injuries, by firearm or otherwise;
- A drug overdose or carbon monoxide inhalation;
- Attempted suicide or suicide while sane or insane;
- Flying in, descending from or being exposed to any hazard related to an aircraft while receiving flying lessons, being flown for a parachute jump, performing any duties in connection with the aircraft, or a member of the armed forces if the aircraft is under the control by the armed forces;
- The hostile action of any armed forces, insurrection or participation in a riot or civil commotion;
- Full-time service in the armed forces of any country;
- Participation in a criminal offence.

How to Claim

Your Benefits Administrator or your Human Resources Department will provide the claim forms and any assistance required to prepare the claim.

Dependent Life

Spouse	\$10,000
Dependent Child(ren)*	\$ 5,000

* Birth to 21 years (or age 25 if a full-time student)

Benefit

A lump sum Dependent Life benefit is paid in the event of death of an insured dependent from any cause while you are covered under this plan.

Beneficiary

You, the employee will be the beneficiary for this benefit.

Proof of Claim

If a dependent dies, proof of claim should be made as soon as possible after the death occurred.

Waiver of Premium

If you become totally disabled prior to age 65 and your Basic Group Life Insurance premium is waived, your Dependent Life Insurance premium will also be waived for as long as this Dependent Life Insurance plan remains in force and you remain totally disabled prior to your 65th birthday.

Termination of Coverage

Dependent Life coverage terminates on the earliest of:

- your 70th birthday;
- termination of your Basic Group Life coverage;
- termination of your eligibility for Dependent Life Insurance for any other reason.

Conversion Privilege

Dependent Life Insurance may be converted to an individual policy should eligibility under your group policy be terminated. Please see your Benefits Administrator for further details.

Survivor Benefit

Dependent Life insurance for your dependents will continue for 24 months and the premiums otherwise required for dependent coverage will be waived should you die while insured for this benefit. For full details please contact your Benefits Plan Administrator.

How to Claim

Your Benefits Administrator or your Human Resources Department will provide the claim forms and assistance required to prepare the claim.

Long Term Disability

Elimination Period:	120 calendar days
Own Occupation Period:	Two (2) years
Monthly Benefit::	75% of monthly pre-disability earnings
Maximum Benefit Period:	To age 65, recovery or death, whichever occurs first
Maximum Monthly Benefit::	\$6,000
Benefit Tax Status:	Taxable

Benefit payments are calculated as a percentage of your pre-disability earnings.

This benefit is NOT AVAILABLE to volunteer fire-fighters, ambulance persons, elected officials or returning seasonal employees unless otherwise stated in the Benefit Plan Summary.

Benefit

Long Term Disability (LTD) is an important benefit. It is designed to provide income replacement in the event a prolonged serious illness or injury prevents you from working.

Elimination Period

This is the period of time during which an insured employee must be totally disabled before commencement of benefits. Long Term Disability benefits commence on the day following the completion of the elimination period.

Proof of Claim

Written proof of claim must be furnished to the insurance company (completed claim forms) within 90 days of the completion of the elimination period. It is recommended that the application for benefits be submitted during the elimination period as processing of applications may require six to eight weeks.

Failure to provide proof within 90 days after completion of the elimination period will not invalidate nor reduce any claim if it is shown that proof of loss was provided to the insurance company as soon as was reasonably possible. In no event will the time for filing the proof of loss be extended for more than 90 days plus one year after the completion of the elimination period.

Payment of Benefit

The benefit is payable monthly in arrears. Benefits for a partial month are calculated at the rate of 1/30th of the monthly benefit multiplied by the number of days of total disability.

Tax Status

The monthly benefit is taxable if the employer pays any or all of your Long Term Disability premiums. In this circumstance a T4 A Slip would be issued by the insurance company. If, however, you paid all of your own Long Term Disability premiums, the benefit would not be taxable.

Definition of Disability

- You are considered totally disabled if during the elimination period and any own occupation period (as shown in your Benefits Plan Summary), as a result of illness or injury, you are continuously unable to perform substantially the essential duties of your regular occupation, and;
- Thereafter, the inability, as a result of illness or injury, to engage in any occupation for which you are qualified or may be reasonably be qualified by reason of training, education or experience. (The lack of available or suitable employment does not have any bearing on continuation of benefits.)

Loss of Permit

If you are required to hold a government permit or license in order to perform your own occupation, the withdrawal or non-renewal of the permit or license because of an accident or sickness incurred while insured by this benefit will satisfy the definition of total disability for up to 12 months during the own occupation period, provided you are not gainfully employed.

After 12 months total disability will be based on the portion of the definition that applies after the own occupation period so that the withdrawal or non-renewal of the permit or license will not qualify as total disability by itself.

Pre-Existing Condition Limitation

No benefits are payable for any disability commencing within 12 months after the effective date of insurance under this plan for which you have received medical treatment or attention during 90 days prior to the effective date of this insurance. However if you should become totally disabled with any other illness or injury for which medical attention had not been received 90 days prior to being covered under this plan you would be eligible to file a claim under this benefit.

Recurrent Disability

In connection with the satisfaction of an elimination period, if you, within 30 days of returning to work following a period of total disability, again become totally disabled due to the same or related causes, the latter period of disability is considered a continuation of the previous period. However, no more than two periods of total disability may be used to satisfy an elimination period.

Within six months of returning to work after having received Long Term Disability benefits, if you suffer a recurrence of the same disability, the Long Term Disability benefit will be reinstated without a waiting (elimination) period.

The insurance company is not liable for recurrence of total disability which occurs both after termination of your insurance under this benefit and a period of 180 days during which you are not totally disabled.

Integration of Benefits

The Long Term Disability payment will be coordinated with other income benefits as follows:

- your monthly benefit will first be directly reduced by any amount you receive under Workers' Compensation or Canada Pension Plan, and;
- if in addition to the above-mentioned benefits, you receive disability income from other sources*, your monthly disability benefit will be reduced so by the amount of income from all other sources.

Other Sources of Income include:

- benefits for the same or related disability under any government plan to the extent permitted by law. This includes but is not necessarily limited to the Canada/Quebec Pension Plan (primary), Workers' Compensation and automobile insurance benefits;
- benefits of any kind from a retirement plan that includes employer contributions. (You are not required to take early retirement or apply for a disability benefit which would result in a reduction of your retirement benefits.);
- benefits for the same or related disability under any other plan underwritten on a group basis;
- payments of any kind made by an employer during the period of disability.

Exclusions and Limitations

No benefit is payable for disability due to:

- intentional self-inflicted injury while sane or any self-inflicted injury while insane;
- medical or surgical care which is cosmetic;
- committing or attempting to commit a criminal offence, other than operating a motor vehicle while the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);
- insurrection or war, whether or not declared or participating in a riot, except in the case of policeperson or fire/ambulance person in the performance of his/her duties;
- cosmetic surgery except to the extent necessary to repair disfigurement due to an injury sustained while insured;
- substance abuse after the first 24 months following the completion of the elimination period unless:
 - you are confined in a hospital; or
 - there is also a condition present which could qualify for disability benefits from the insurance company even if the substance stopped.
- Benefit payments do not commence:
 - during any leave taken pursuant to provincial or federal law or pursuant to mutual agreement between you, the insured employee, and your employer;
 - during any period of lay-off, strike or lock-out for any disability incurred after notice of any period of lay-off, strike or lock-out;
 - for disability during any period of imprisonment.

Termination of Total Disability Benefits

Total disability benefits terminate on the earliest of:

- the date you cease to be totally disabled;
- the date you engage in any occupation for wage or profit;
- the date the maximum benefit period applicable is attained;
- the date which is the last day of the month in which you turn age 65;
- the date you fail to furnish satisfactory evidence of continuance of total disability, or fail to submit to medical examinations as required by the insurance company;
- the date you are no longer receiving regular and personal medical supervision and treatment by a legally qualified physician considered satisfactory by the insurance company;
- the date which is the last day of the month, following the date of your death;
- the date you refuse to enter into any medical vocational rehabilitation program, which is reasonably considered by the insurance company and its advisors to be appropriate;
- the date the Rehabilitation Benefit becomes payable to you under this benefit.

Termination of the Long Term Disability Plan

If your Long Term Disability plan terminates, you will continue to receive the benefit as long as you remain totally disabled. You must be under the regular care of a physician and/or specialist at all times during the disability.

Survivor Benefit

If you die while receiving long term disability benefits, the insurer will pay a survivor benefit equal to three times your last monthly payment. Payment will be made to the employee's spouse, if living. If the spouse is deceased, payment will be made to dependent children in equal shares. If there are no dependents payment will be made to the estate.

Waiver of Premium

If you become totally disabled prior to age 65 and you remain disabled for a period equal to or greater than your elimination period (as shown in Your Benefits Plan Summary), your Long Term Disability Insurance premiums may be waived for as long as you remain totally disabled prior to your 65th birthday. The insurance company will automatically advise you and your employer of this provision.

Premiums are payable during your elimination period, but if you qualify for waiver of premiums; no further premiums will be required for the duration of the disability.

Rehabilitation

As an incentive to encourage your return to employment, you may perform certain work as approved by the insurance company, before full recovery without losing benefits under this program.

The rehabilitation Benefit is the monthly benefit payable for total disability after taking into account the Integration of Benefits provision, further reduced:

- by 50% of the monthly income earned by the insured employee; and
- to the extent necessary so that total benefits from all sources do not exceed 100% of the employee's gross income if benefits payable are taxable or net-income if benefits payable are non-taxable.

Definitions

Gross Income means your regular monthly rate of earnings from your employer excluding bonus, overtime pay and all other extra compensation.

Net Income means your gross income less the amount of tax payable on it based on your province of residence.

Pre-disability income means gross income if your benefit is taxable and net income if your benefit is non-taxable.

How to Claim

For full details on "rehabilitation" see your Benefits Plan Administrator.

If you are absent from work due to total disability, and it appears that the disability is likely to continue beyond the elimination period (typically 90 to 120 calendar days), contact your Benefits Administrator and begin the LTD application process. It is important to submit the application as early as possible to avoid initial payment delay and to allow the insurer to assist in the rehabilitation process. Your Benefits Administrator will be able to assist you with your claim form.

Canada Pension Plan Disability (CPP)

Insured individuals who apply for Long Term Disability will be advised to also apply for the Canada Pension Plan Disability (CPP) benefit. Any payments from CPP will reduce the amount of benefit from the LTD plan. Canada Pension Plan awards take approximately four months to process and once approved, you are advised by CPP of the amount of benefit payable and any retroactive entitlement.

A copy of the CPP notice of benefit should be given to your payroll supervisor so that it may be forwarded to the insurance company. A Canada Pension Plan offset will be effective from the date of the commencement of the LTD benefit, and any amount that you receive from CPP will be repayable to the insurer. It is therefore advisable that you do not spend the initial lump-sum CPP payment before reimbursing the insurance company

Best Doctors

Best Doctors[®] is a new program that will be offered to all employees who qualify for Short or Long Term Disability.

If you or one of your covered dependents becomes seriously ill or injured, you can contact Best Doctors. They will connect you and your treating physicians, with world renowned specialists who will confirm the right diagnosis and the right treatment options without you ever having to leave your home.

Best Doctors provides medical information and expert advice to help you answer your medical questions. You'll be empowered with knowledge, guidance and support while dealing with your illness or injury.

From finding a medical specialist to providing health coaching, wellness and health assessment tools, access to clinical trials, nutritional information, comprehensive medical information and more, Best Doctors offers a full spectrum of services that will help you get – and stay as healthy as possible.

For more information about Best Doctors, please call **1-877-419-BEST (2978)**, visit www.bestdoctorscanada.com, or view an interactive presentation at www.bestdoctorscanada.com/overview.

Extended Health Care (Drug Card)

Extended Health Care benefits provide coverage at 100% reimbursement for prescription drugs and 100% reimbursement for all other reasonable and customary eligible expenses.

Your group participates in the Shared Health Network pay direct system (plastic card) for prescription drugs. Expenses for other eligible health services and medical devices are paid by the insurance company on a reimbursement basis.

Eligible expenses must be reasonable and customary, professionally recognized and medically necessary. This brochure provides you with a general overview, however, if you have specific questions that are not covered here please see your Benefits Plan Administrator.

Survivor Benefit

Extended health benefits for your dependents will continue for 24 months and the premiums otherwise required for dependent coverage will be waived should you die while insured for this benefit. For full details please contact your Benefits Plan Administrator.

Prescription Drugs

Charges for drugs and medicines (including contraceptive drugs) which by law may only be obtained with a physician's prescription, prescriptions must be written by a physician, or where legally permissible, a licensed, certified or registered health practitioner. Charges for serums and vaccines prescribed for preventing illness are included. Dispensing fee maximums are indicated in the Benefits Plan Summary.

No benefits are payable for:

- drugs purchased with a prescription that could have been purchased over-the-counter (without a prescription); Some plan designs accept over-the-counter medications, see your Benefit Plan Summary;
- drugs purchased without a prescription, or dispensed by a person not legally licensed to do so;
- drugs exceeding a 90 day supply;
- drugs insured or paid for by a government plan;
- anti-obesity drugs;
- experimental drugs.

Health Services – Paramedical

Specialist	Maximum per person per calendar year @ 100% unless noted below	Referral Required
Acupuncturist ¹	\$750	No
Audiologist	\$750	No
Chiropractor ²	\$750	No
Dietician	\$750	No
Massage Therapist	\$750	No
Naturopath	\$750	No
Occupational Therapist	\$750	No
Osteopath ²	\$750	No
Physiotherapist	\$750	No
Podiatrist/Chiropodist ²	\$750	No
Psychologist	\$750	No
Social Worker	\$750	No
Speech Therapist	\$750	No

- ¹ Charges by physicians, approved by the College of Physicians and Surgeons to practice acupuncture;
- ² Up to one diagnostic x-ray examination in each calendar year for each insured person, per specialty.

Accidental Dental

Replacement or repair of natural teeth which are damaged as a result of a direct blow to the mouth, but not by an object knowingly or unknowingly placed in the mouth. A dental injury must be sustained while the person is insured for this benefit, and the expense for replacement or repair must be incurred within three years from the date when the dental injury is sustained. Charges qualify as eligible expenses up to an overall maximum of \$1,000 for each insured person, for any one dental injury.

Ambulance

Charges for a licensed ambulance service or other emergency service transportation including commercial airline when used to transport you or your insured dependents from the place where injury or illness is suffered to the nearest hospital where adequate treatment is available are covered. Response charges (where an individual is not transported to a hospital) is covered. There may however be restrictions of coverage in the event of fraudulent use of ambulance services or violence by the patient towards the ambulance staff.

Auxiliary/Convalescent Hospital

Charges for room and board in auxiliary/convalescent hospitals approved by the appropriate provincial hospital authority, provided you or your insured dependents are admitted to the facility within 24 hours following the period of in-patient care in an active treatment hospital. Such benefit will be reduced by amounts payable under any provincial or federal plan covering such expenses and will be limited to a maximum of 180 days for any one disability. This benefit is for recuperative/rehabilitative care. It does not provide coverage for custodial care.

Equipment and Other Supplies

- purchase of approved braces (utilizing durable and rigid material), crutches, canes, walkers, and artificial eyes required as a result of illness or injury;
- with prior approval of the insurance company, purchase of prosthetic devices required as a result of illness or injury; charges for duplicate prostheses do not qualify; charges for breast prostheses following surgery qualify as eligible expenses up to a max of \$200 per person in a benefit year;
- with prior approval of the insurance company, rental of a standard wheelchair, hospital-type bed, iron lung, oxygen tent, or other durable equipment for temporary therapeutic use required as a result of illness or injury, or purchase of similar equipment at the discretion of the insurance company; charges for the purchase of an electric wheelchair qualify as eligible expenses up to a lifetime maximum of \$4,000 per insured person;
- oxygen and blood serum;
- the purchase of up to two mastectomy brassieres per insured person in any calendar year;
- the purchase of up to two pairs of prescribed surgical stockings per insured person in any calendar year;
- the purchase of foot orthotics as recommended by a physician or podiatrist; up to a calendar year maximum of \$400 per insured person. The devices must be custom made and medically required for everyday use.
- the purchase of wigs required as a result of chemotherapy; up to a maximum of \$500 per insured person during any three calendar years;
- diagnostic tests, laboratory tests, radium treatment and x-ray examinations;
- one pair of orthopedic shoes including orthopedic alterations to standard shoes, if prescribed by a physician or podiatrist, up to a maximum of \$400 in any calendar year;
- colostomy and ileostomy supplies;
- cosmetic surgery necessary to repair disfigurement due to an injury sustained while insured;
- needles and syringes for diabetics; charges for diabetic PEN's are eligible, but only to the extent that charges for needles and syringes would be payable.
- eye examinations performed by an ophthalmologist or a licensed optometrist, up to a maximum of one visit per person over any period of 24 months. The maximum payable is based on usual and customary charges. Exams for dependent children under 18, up to a maximum of one visit per person over any period of 12 months.

Hearing Aids

Charges for the cost and installation of hearing aid(s) purchased on the written recommendation of a physician. Charges qualify as eligible expenses up to \$800 in any period of 5 consecutive calendar years.

Hospital Benefits

Charges for semi-private accommodation in an active treatment facility. If private accommodation is used the plan will pay a maximum of \$8.00 per day for the differential between semi-private and private room charges.

Nursing

Charges for the services of a registered nurse, registered nurse's assistant (RNA) or a licensed practical nurse who is not a relative of the patient or a resident in the patient's home, if the service is prescribed by a physician and is rendered outside the hospital. The maximum benefit is \$25,000 in any three consecutive calendar years unless the claimant is over 65 at which time the maximum becomes \$5,000 per lifetime.

Charges for the following services are excluded:

- custodial care rendered by a nurse;
- any service within the capabilities and competence of a member of the household;
- services provided while the insured person is hospitalized.

Out-Patient

Charges by a hospital for use of out-patient facilities or for supplies where such charges are not covered under the respective provincial hospital plans.

Outside Province Emergency Coverage (within Canada)

Reasonable and customary charges for the following services will be eligible when received outside your normal province of residence due to an emergency occurring while you are travelling:

- hospital room and board;
- hospital medical services and supplies;
- physician services;
- prescription drugs;
- licensed ground ambulance or transportation by commercial airline to the nearest hospital where adequate treatment can be provided.

Outside Province Referrals

If you require this service please contact your Benefits Administrator for details.

Exclusions and Limitations

Eligible expenses will not include any charges incurred directly for, or as a result of any one or more of the following:

- declared or undeclared war or any act thereof, except in the case of a police person or fire/ambulance person while engaged in the performance of his/her duties;
- insurrection, rebellion, participation in a riot or act of civil disobedience, except in the case of a police person or fire/ambulance person while engaged in the performance of his/her duties;
- intentionally self-inflicted injury sustained while the insured person is sane or any self-inflicted injury sustained while insane;
- committing or attempting to commit a criminal offence other than operating a motor vehicle while the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);
- cosmetic surgery except to the extent necessary to repair disfigurement due to an injury sustained while insured;
- an examination by, or the services of a physician if required solely for the use of a third party;
- dental treatment or supplies except for dental injury sustained while insured;
- treatment for temporomandibular joint dysfunction;
- treatment, supplies or procedures which are not recommended by a physician or those for which the insured is not required to pay;
- treatment, supplies or procedures which are not approved by the Canadian Medical Association or which, in the opinion of the insurance company medical advisors, are clearly experimental;
- durable equipment which is required for participation in recreational activities but which is not otherwise required for normal day-to-day activities.
- Expenses for personal convenience, exercise, self-help environmental control items which may also be used for non-medical reasons are not eligible.

Coordination of Benefits – Drugs

- If you use a pharmacy that has the ability to coordinate electronically with both your spouse's and your Assure Card, then the coordination of benefits will occur at point of purchase.
- If your spouse's insurance company does not use electronic processing and your spouse's plan is the first payer, a claim form will be required (see your Benefits Administrator for assistance).
- If your plan is the first payer and does not cover the full cost of the drugs dispensed you may be eligible to coordinate the outstanding balance with your spouse's plan. If your spouse's plan does not use direct electronic processing original receipts must be submitted on a claim form for consideration.

Coordination of Benefits

An employee or dependent may be entitled to Extended Health Care or Dental Care benefits from both this plan and another group plan. If duplication occurs, in any or all of the plans, benefits will be coordinated so that the benefits from all plans will not be more than the total expenses. Under this circumstance benefits will be coordinated in the following manner:

- Eligible expenses for you, the employee, must first be submitted to this plan for payment.
- Eligible expenses for your spouse must first be submitted to his/her plan for payment.
- Eligible expenses for your dependent children are submitted first to the plan of the parent whose birthday falls earliest in the calendar year. For example, if your birthday is February 18th and your spouse's birthday is February 5th the expenses would first be submitted to your spouse's plan and any outstanding eligible expenses would then be submitted to your plan.
- Once you have determined which plan is the first payer, submit claim forms and receipts and request return of receipts. When you receive payment submit a claim form to the second payer, and attach the claim statement from the first payer.

Coordination of Benefits for Employee and/or Spouse over age 65

Employees and/or spouse age 65 or over are covered for Health benefits through the Alberta Seniors Blue Cross Plan.

Conversion Privilege

You have the option to purchase individual health coverage if you need this type of insurance once your group benefit terminates. You can purchase health insurance without providing proof of good health, subject to certain conditions. For example, you must be under age 75 and apply within 60 days from the date your group coverage for this benefit ends.

How to Claim

For drug claims processed electronically you will use your Assure Card. For drug claims not purchased with your Assure Card (electronic process not available or card not yet issued to you) the Extended Health Care claim form must be completed and mailed together with receipts to the address shown on the reverse side of the claim form.

For other eligible expenses, complete and sign the extended health claim form and mail together with original receipts to the Sun Life claims office. The address is found on the reverse side of the form. Keep a copy of the form and the receipt for your records.

Pre-determination of Devices and Equipment

Pre-determination of medical equipment is recommended as the purchase may not be reimbursed at the level you expected. Complete an extended health claim form and send it with a physician's prescription and an estimate from the medical equipment provider.

Proof of Claim

Upon receipt of proof (completed claim form and receipts) that you or your insured dependents have incurred eligible expenses as a result of illness or injury, the insurance company will pay a benefit not to exceed the maximums.

Eligible expenses must be received by the insurance company within 180 days following the end of the calendar year in which the expenses were incurred.

If this policy terminates, or your employment terminates, claims must be submitted within 90 days after the termination date.

Claim Statement and Receipt Return

A Claim Statement will be issued with your claim cheque and it will serve as a tax receipt. If you require the original receipts to be returned for coordination of benefit purposes, please write the request on the claim form.

Medi-Passport

Travel Assistance Benefits Provided by Sun Life through EUROP ASSISTANCE Services Inc.

Medi-Passport coverage provides protection against medical and other emergencies while you and your family are travelling. The maximum duration of coverage is 60 days per trip. Reimbursement is limited to a maximum of \$1,000,000 per medical emergency.

About EUROP ASSISTANCE

Europ Assistance is an international medical and travel assistance organization with participating medical facilities, transportation providers, medical staff and agents in many countries. Its Head Office in Washington, DC is staffed by multilingual operators, doctors, nurses and travel experts who are specially trained to respond to emergencies. Your call to Worldwide Assistance will be answered 24 hours a day, 7 days a week. Help is arranged immediately, on the spot, for medical, legal and travel related emergencies.

What You Have To Do

Always carry your Medi-Passport card with you when travelling. If you need emergency help anywhere in the world* call toll free (Canada and USA) or collect, using the phone numbers shown on your Medi-Passport card. You may also fax a message. Help is given immediately and continues to be given until the emergency situation is resolved.

NOTE: You must call the Europ Assistance hotline to establish your claim. *see Limitations.

Medical Assistance

Europ Assistance operators cut through language barriers and speak to the local officials or hotel/hospital staff in their own language. You are directed to the appropriate medical facility or a local doctor or pharmacist. Europ Assistance keeps in touch with the medical situation and may consult the family doctor at home. Europ Assistance notifies the family and arranges, if necessary, for a visit to the sickbed. (Expenses and fare are provided.) Ground or air ambulance is available for transportation to the nearest hospital equipped to treat the emergency. If a foreign hospital or doctor requires an up-front payment to commence treatment, Europ Assistance arranges for this and for payment to the provider.

- All in-hospital services and supplies and all prescription drugs are covered.
- If judged necessary, the patient may be moved to a hotel for convalescence before repatriation, for up to 5 days, with an expense allowance of \$75 per day.
- If it is advisable to bring the patient home and he/she is fit to travel, the one way fare is paid, and transportation arranged, with an attendant if necessary.

Family Benefits

Medi-Passport provides Family Benefits of up to \$5,000 for the following situations:

- If the adult plan member is hospitalized, unattended dependent children under age 16 will be transported back home. Europ Assistance will arrange for a qualified escort if necessary.
- If the patient is alone, the visit of one family member (spouse, parent, brother or sister) to bedside will be arranged at the round trip economy fare and living expenses of \$150 per day will be paid for seven days.
- If due to a medical emergency, the family members cannot use their original return tickets and have no trip cancellation insurance, a one-way economy ticket will be provided for each.

Return of Car

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

Burial Expenses

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

Additional Benefits

Urgent Messages - In emergency personal messages to home, office or friends may be left at the Europ Assistance Operations Centre for transmittal. Messages for the patient may be left with Europ Assistance and will be relayed when the patient calls the Hotline.

Interpretation - In an emergency Europ Assistance can provide telephone interpretation services in most major languages.

Legal Assistance - Europ Assistance will find a local legal advisor if needed. Europ Assistance can also help arrange advances on credit cards or contact the family to post bail or pay legal fees.

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

Exclusions and Limitations

- For emergency services that cost \$200 or less, the patient makes payment and keeps the receipts. These claims are submitted to Sun Life of Canada on return to Canada.
- There are countries where Europ Assistance is not currently available for various reasons. Call Europ Assistance before your departure. Also check the Canadian government website <http://www.voyage.gc.ca> for travel warnings and current issues or call them at 1-800-267-6788.
- Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- The refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

Terms of Coverage

The maximum duration of coverage is 60 days per trip. Maximum reimbursement is limited to \$1,000,000 per medical emergency for insured individuals.

Vision Care

Your Vision Care plan provides a \$500 Vision Care benefit.

Charges for either:

- Conventional lenses and frames, contact lenses up to the maximum benefit during any period of two years for persons 18 years or over, or one year for those under 18 years of age. Eligible expenses for eyeglasses include glasses, prescription sunglasses, and prescription safety glasses with single vision, bifocal or trifocal lenses or;
- Laser eye surgery up to the maximum benefit;
- Cost of contact lenses prescribed by an Ophthalmologist if considered to be medically necessary or required to improve vision to at least 20/40 if this is not possible to do with conventional glasses up to a lifetime maximum for each insured person of \$500.

If a person's eyesight has changed sufficiently, in the opinion of an Ophthalmologist or Optometrist, to justify a change in prescription more frequently, the above time limitations shall not apply. The change must be at least 0.25. The claim must be submitted through AMSC. If the claim is sent directly to Sun Life it will be declined.

Send a completed Health Claim form to AMSC along with the following documents:

- most recent prescription;
- copy of the previous prescription;
- copy of paid invoice for the glasses;
- copy of paid invoice for the eye exam, if applicable.

Eye examinations performed by an ophthalmologist or a licensed optometrist, up to a maximum of one visit per person over any period of 24 months. Exams for dependent children under 18, up to a maximum of one visit per person over any period of 12 months. The maximum payable is based on usual and customary charges.

Note: The exam is covered under the extended health care benefit; the expense is not added to your maximum vision benefit.

Exclusions and Limitations

Allowable expenses cover basic lenses and frames only. Non-glare coating is not an eligible expense. Hardex is an eligible expense for dependent children under the age of 18.

Preferred Vision Services (PVS)

You can save up to 20% on the purchase of all frames, prescription lenses, contact lenses and lens add-ons at registered PVS locations. To find a participating practitioner near you visit www.pvs.ca or call 1-800-668-6444. After selecting your eyewear, tell the practitioner that you are covered under a plan through Sun Life Financial and pay the reduced price.

How to Claim

To make vision claims, first pay for the service, then complete an extended health claim form and mail it with original receipt to the Sun Life office in Edmonton. The address is on the claim form.

You may also go online to submit eye exam and vision purchases for direct deposit into your bank account. Go to www.mysunlife.ca and click on 'Register Now'. For claims inquiries please contact Sun Life at 1-866-246-4153.

Claim Statement and Receipt Return

A Claim Statement will be issued with your claim cheque and it will serve as a tax receipt. If you require the original receipts to be returned for coordination of benefit purposes, please indicate in the space allotted on the claim form.

Dental Care

Basic and Diagnostic:	100% Reimbursement	}	\$1,500 Combined Maximum
Dentures:	100% Reimbursement		
Major Restorative:	80% Reimbursement	}	\$1,500 Lifetime Maximum
Orthodontics:	50% Reimbursement		

The benefit calendar year maximum is \$1,500* per insured person for all coverage's combined excluding Orthodontics for which there is a \$1,500 lifetime maximum.

****Employees whose insurance becomes effective on or after July 1st of any year will be limited to \$750 per insured for the balance of the calendar year.***

PLEASE READ THIS CAREFULLY PRIOR TO DENTAL TREATMENT

Allowable expenses will not exceed the combined calendar year benefit maximum per insured person for all Dental services as outlined in the Benefit Plan Summary with the exception of:

- Employees whose insurance becomes effective on or after July 1st of any year will be limited to 50% of the combined calendar year benefit maximum per insured person for the balance of the calendar year.
- For Dental procedures that begin in one calendar year and are completed in the next calendar year, the claim will be paid out of the annual maximum of the calendar year in which the work is completed.
- No expenses will be reimbursed for Dental procedures that begin while the employee is eligible but are completed after termination of employment.
- Allowable Dental Care expenses are payable at the current fee guide for general practitioners approved by the Dental Association in the employee's province of residence, regardless of where the treatment is received.
- If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practise is limited to that specialty, then the fee guide approved by the provincial Dental Association for that specialist will be used.
- Should you or your dependents require Dental Care treatment which will be in excess of \$500 you should obtain a pre-authorization from the insurance company. The Dental Care claim form can be used for this purpose. The insurance company will process the pre-authorization and advise you of the allowable expenses under your Dental Care plan. This process provides you with the dollar value that is covered for the specific treatment. Pre-authorizations are not provided over the phone. You should allow approximately two to three weeks from date of mailing for a response.
- If you have Dental coverage under more than one Dental Care plan the eligible expenses will be coordinated between the two plans. Please refer to "How to Claim" for coordination of benefits.

Survivor Benefit

Dental benefits for your dependents will continue for 24 months and the premiums otherwise required for dependent coverage will be waived should you die while insured for this benefit. For full details please contact your Benefits Plan Administrator.

Basic & Diagnostic Dental Care

Diagnostic - Routine examinations and diagnosis

- complete examinations, once every two years

- recall examinations, twice in any calendar year, but repeat procedures must be separated by six months
- specific and emergency examinations

Dental x-rays and interpretation

- full mouth, once every two years
- bitewings, twice in any calendar year, but repeat procedures must be separated by six months
- periapical, intra-oral and extra-oral films
- routine diagnostic and laboratory procedures
- evaluations and x-rays
- habit breaking appliances for dependent children who have not attained their 21st birthday
- **Preventive** oral hygiene instruction, lifetime limit; once per person

Surgical

- surgical exposure of teeth
- removal of tumours, cysts, residual roots, foreign bodies from the mouth
- alveoloplasty, gingivoplasty, stomatoplasty and osteoplasty
- frenectomy
- miscellaneous surgical and post-surgical services
- fractures, including assisting a surgeon at fracture reduction (with a maximum of \$100 per occurrence); repair of soft tissue lacerations
- general anaesthesia and sedation in connection with the above procedures
- Minor surgical procedures
 - simple extractions, post surgical care
 - soft tissue incision and drainage
- Complicated extractions
 - impacted teeth and residual roots, local or general anaesthesia in connection with the above procedures

Removable Prosthodontics - Repairs, adjustments Relines, rebasing

- once in any calendar year

Space Maintainers - Space maintainers for missing primary teeth

- only dependent children who have not attained their 21st birthday

Restorative - Fillings, retentive pins

- silicate, acrylic, composite, amalgam for all teeth
- stainless steel crowns for dependent children who have not attained their 21st birthday

General

- Emergency treatment of pain and emergency consultations

Endodontic

- pulp capping and pulpotomy
- root canal therapy, apexification
- periapical services
- gingival surgery, alveolectomy, hemisection
- intentional removal, filling and reimplantation
- emergency procedures

Periodontal

- non-surgical treatment of gum disorder
- surgical services and post-surgical treatment

- occlusal adjustments; maximum of 8 units in a calendar year
- provisional splinting
- scaling and root planing; maximum 10 units in a calendar year
- appliances, excluding athletic mouth guards
- maintenance, adjustment, repair to appliances; twice in a calendar year

Major Restorative Services

Single Restorations

- inlays, only covered up to what would normally be paid for a regular filling
- onlays

Preventive pins; post and cores

- removal, recementation of crowns
- crowns, use of porcelain restricted to teeth 1-6 only
- replacement of crowns and onlays that are at least 5 years old and cannot be made serviceable
- implant-related crowns
 - Sunlife will pay the benefit that would have been payable for a tooth supported crown or non-implant related prosthesis.
 - All other expenses related to implants, including surgery charges are not covered.
- veneers

Fixed Bridges

- retainer onlays; porcelain restricted to teeth 1-6 only
- implant-related bridges
- retentive pins; post and cores, copings
- repair, recementation of existing bridgework
- initial provision of fixed bridgework if necessary due to the extraction of one or more natural teeth while dental insurance is in force under this policy
- removal and replacement of fixed bridgework as long as:
 - the existing appliance is at least 5 years old and cannot be made serviceable;
 - the existing appliance is temporary and is replaced by a permanent bridge within 12 months of its installation;
 - the replacement is necessary because of the extraction of one or more natural teeth while dental insurance is in force under this specific plan.

Dentures

Removable Prosthodontic Services (Dentures)

- Initial provision of full or partial removable prosthodontics including implant-related prosthodontics if necessary due to the extraction of one or more natural teeth while the person is insured for this benefit.
- Replacement of, or addition to, existing removable prosthodontics, provided:
 - the existing appliance is at least 5 years old and cannot be made serviceable; or
 - the existing appliance is temporary and within 12 months of its installation it is replaced by a permanent prosthodontic; or
 - the new appliance is necessary due to the extraction of one or more natural teeth while the person is insured under this benefit.
- Stress breaker attachment

Orthodontics

Orthodontic Services are available for dependent children who have not attained their 21st birthday. Some plan designs accept adult orthodontics; please refer to the Benefits Plan Summary.

Orthodontic Services

- diagnosis and x-rays to establish treatment for the correction of malocclusion
- interceptive, intervention or preventive services
- provision of fixed or removable appliances
- full banding and retention; appliance therapy
- repairs, adjustments, recementation (maximum \$30 plus laboratory charges per occurrence)

If the course of treatment is longer than 12 months, the insurance company will determine the average monthly amount of the expenses and will pay three times the average in quarterly instalments for the duration.

If the course of treatment is expected to last less than 12 months, the insurance company will make payments on a monthly basis, based on the expenses incurred for the month.

Exclusions and Limitations

(Applied to ALL Dental Coverage - Basic, Major Restorative, Dentures and Orthodontics)

Exclusions

No benefits are payable for expenses resulting directly or indirectly from any of the following:

- declared or undeclared war or any act therefore, except in the case of a police person, fireperson, or ambulance person while engaged in the performance of such duties;
- insurrection, rebellion, participation in a riot or act of civil disobedience, except in the case of a police person, fireperson or ambulance person while engaged in the performance of such duties;
- intentionally self-inflicted injury while sane or any self-inflicted injury while insane;
- committing or attempting to commit a criminal offence, other than operating a motor vehicle while the blood contains more than 80 milligrams of alcohol in 100 millilitres of blood (.08%);
- broken appointments, third party examinations, travel to and from appointments, or completion of claim forms;
- the replacement of removable appliances which are lost, mislaid or stolen;
- diagnostic casts (study models);
- dental care which is cosmetic;
- a full mouth reconstruction, vertical dimension correction, temporomandibular joint dysfunction, endodontics and coping with respect to overdentures, the placing of crowns to restore occlusal height, the permanent splinting of teeth, or implant-related surgery or equipment;
- dental treatment not approved by the Canadian Dental Association or which is experimental in nature;
- recent duplication of services, whether by the same or different dentist.

Limitations

When there are two or more courses of dental treatment available to correct a dental condition, the insurance company will base reimbursement on the cost of the least expensive treatment that will provide a professionally adequate result.

No benefits are payable for dental services:

- that are payable under any Government Plan;
- that are not permitted by law to be paid;

- for which there would be no charge other than for the existence of insurance;
- which are provided by any other Plan or arrangement except in accordance with the coordination of benefits provision

Coordination of Benefits

An employee or dependent may be entitled to Extended Health Care or Dental Care benefits from both this plan and another group plan. If duplication occurs, in any or all of the plans, benefits will be coordinated so that the benefits from all plans will not be more than the total expenses. Under this circumstance benefits will be coordinated in the following manner:

- Eligible expenses for you, the employee, must first be submitted to this plan for payment.
- Eligible expenses for your spouse must first be submitted to his/her plan for payment.
- Eligible expenses for your dependent children are submitted first to the plan of the parent whose birthday falls earliest in the calendar year. For example, if your birthday is February 18th and your spouse's birthday is February 5th the expenses would first be submitted to your spouse's plan and any outstanding eligible expenses would then be submitted to your plan.
- Once you have determined which plan is the first payer, submit claim forms and receipts and request return of receipts. When you receive payment submit a claim form to the second payer, and attach the claim statement from the first payer.

Conversion Privilege

You have the option to purchase individual dental coverage if you need this type of insurance once your group benefit terminates. You can purchase dental insurance without providing proof of good health, subject to certain conditions. For example, you must be under age 75 and apply within 60 days from the date your group coverage for this benefit ends.

How to Claim

The majority of dental offices now submit claims electronically in real-time to Sun Life through CDAnet™. If you submit a claim using the dentist's Standard Dental Claim Form and wish to have the dentist paid directly by the insurer, sign in the appropriate space.

You may also go online to submit some dental claims for direct deposit into your bank account.

Go to www.mysunlife.ca and click on 'Register Now'. For claims inquiries please contact Sun Life at 1-866-246-4153.

Pre-determinations for dental treatment in excess of \$500 are recommended and may be submitted on the standard form. The dentist will assist you in completing the pre-determination. Please allow time for the authorization to occur prior to your treatment date.

INCOMPLETE FORMS WILL BE RETURNED TO YOU RESULTING IN A DELAY OF PAYMENT

Claim forms are available from your Benefits Administrator or your Human Resources Department.

Proof of Claim

Eligible expenses must be received by the insurance company within 180 days following the end of the calendar year in which the expenses were incurred.

If this policy terminates, or your employment terminates, claims must be submitted within 90 days after the termination date.

Employee Assistance Program (EAP)

*Your Employee Assistance Program is a completely confidential, voluntary and free support service that can help you solve all kinds of problems and challenges in your life. **The number to call is 1-800-387-4765.**

You and your immediate family members (as defined in your employee benefit plan) can receive support over the telephone, in person, online, and through a variety of issue-based health and wellness resources. For each concern you are experiencing, you can receive a series of sessions. You can also take advantage of online tools to help you manage personal well-being.

You'll get practical, relevant support, fast and in a way that is most suited to your preferences, learning approach and lifestyle. Your EAP offers immediate, confidential support for:

Personal Well-Being

- Personal Stress
- Depression
- Grief and loss
- Anxiety
- Aging and midlife issues
- Life transitions
- Mental health and well-being
- Managing anger
- Crisis situations
- Traumatic situations

Relationship Issues

- Communication
- Building health relationships
- Relationship conflict
- Separation/divorce
- Domestic abuse

Family Issues

- Parenting tots to teens
- Blended families
- Family relationships
- Communication
- Single parenting
- Aging parent concerns

Addictions

- Alcohol
- Drugs
- Tobacco
- Gambling
- Other addictions
- Post-recovery support

Workplace Challenges

- Workplace conflict
- Performance worries
- Career planning
- Violence
- Harassment
- Work-life balance
- Work-related stress

*Source: Connect to Health and Well-Being, Shepell-fgi brochure

In addition to the EAP offers you also have access to LifeSpeak on Demand. LifeSpeak on Demand is an innovative online library of streaming video modules that offers you high quality information from North American experts. The topics change annually. Topics that are currently available:

LifeSpeak on Demand

- Understanding Mental Health
- Stress Management
- A shift work Primer
- Cancer 101
- Heart Disease
- Personal Finances
- Couples Relationships
- Retirement-Beyond Work
- Diversity 101
- Cross-Cultural Communications
- Parenting with Connectivity

Health Care Spending Account

Benefit Year

From January 1 to December 31 each Calendar Year.

Plan Credits

The employer will establish a Health Care Spending Account for each covered employee. The employer will allocate plan credits to the employee's Health Care Spending Account, and unused plan credits will be carried forward to be used by the employee. The plan administrator (Sun Life) will pay benefits from the account to cover eligible expenses incurred by the employee or a dependent. The amount of plan credits remaining in the employee's Health Care Spending Account at any given time will be the employee's balance. Please refer to the Benefit Plan Summary for Plan Credit details for your plan.

Time Limit and Proof of Claim

180 days after the end of the benefit year during which a person incurs eligible expenses.

Description of Coverage

The Health Care Spending Account pays for eligible expenses incurred by the employee or a dependent which would qualify as the employee's medical expenses in accordance with Section 118.2(2), or its successor of the Income Tax Act of Canada as amended from time to time, excluding any such expense, or portion of such expense, payable under any other private or government plan.

How Benefits Are Paid

The plan administrator (Sun Life) will pay for eligible expenses taking into account all conditions of the plan and the Coordination of Benefits provision. An eligible expense is incurred on the date the services are received or on the date supplies are purchased or rented. The plan administrator (Sun Life) will not pay more than the employee's account balance when the claim is received by the plan administrator (Sun Life).

Proof of Claim

The plan administrator (Sun Life) must receive proof of claim no later than:

- 180 days after the end of the benefit year during which a person incurs eligible expenses, or
- 90 days after the end of the employee's Health Care Spending Account coverage.

The employee is responsible for all costs associated with any notice or proof of claim.

Notice and Proof Of Claim

The plan administrator (Sun Life) must receive written notice and proof of claim within the time limits shown under each benefit.

From time to time the plan administrator (Sun Life) may request additional information to support a proof of claim. The employee will not be entitled to benefits if the information is not provided by the later of:

- the end of the period specified for proof of claim provision.
- 90 days after the date of the request

An eligible expense is allocated to the year in which it is incurred.

Unused Plan Credits

Subject to the time limit of proof of claim, unused plan credits will be carried forward and can be used by the employee until the earlier of:

- the end of the benefit year following the benefit year during which the plan credits were allocated to the employee's account, or;
- the end of the employee's Health Care Spending Account coverage.

Any plan credits which have been carried forward but remain unused at the end of that period will be forfeited.

Termination

Benefits cease on the date of termination. The employee is responsible for all costs associated with any notice or proof of claim.

Paying Benefits

Benefits payable during the lifetime of an employee are payable to the employee. If an employee dies before the employee's spouse or a dependent child, dependent benefits will be paid to the dependent.

Coordination of Benefits

An employee or dependent may be entitled to Extended Health Care or Dental Care benefits from both this plan and another group plan. If duplication occurs, in any or all of the plans, benefits will be coordinated so that the benefits from all plans will not be more than the total expenses. Under this circumstance benefits will be coordinated in the following manner:

- Eligible expenses for you must first be submitted to your plan. Any outstanding amount may then be submitted to your spouse's plan. Any remaining amount may then be submitted to the HSA. This is done by checking the appropriate box on the extended health claim form.
- Dependents are eligible to claim under the HSA. For details refer to 'Coordination of Benefits' in the Extended Health Care section of this booklet.

Eligible Expenses

Canada Revenue Agency defines which expenses are eligible for reimbursement under an HSA. The following is a partial list of such eligible expenses:

Professional Services

- chiropractor;
- dentist;
- dermatologist;
- naturopath;
- nurse;
- optometrist;
- orthopedist;
- plastic surgeon;
- podiatrist or chiropodist;
- physician;
- physiotherapist;
- psychiatrist;
- psychologist (if licensed by the province to provide therapy or rehabilitation);
- speech therapist (pathological or audiological impediments only);
- Christian Science practitioner; and
- acupuncturist (if a qualified medical practitioner)

Dental Care

- diagnostic/preventative services;
- restorative;
- orthodontic

Facilities and Services

- alcoholism or drug addiction treatment centres, including meals and lodging;
- care in a nursing home;
- care in a self-contained domestic establishment (e.g., own home);
- care in a special school, institution or other place required by reason of a mental or physical handicap);
- a licensed private hospital;
- semi-private or private charges in a hospital;
- care of a person who has been certified to be mentally incompetent;
- care of a blind person; and
- full-time attendants or care in a nursing home (for those confined to a bed or wheelchair)

Medical Equipment and Devices

- all medical equipment and devices prescribed by a medical practitioner;
- artificial eye;
- artificial kidney machine, including reasonable installation, home alteration and operating costs;
- artificial limb;
- blood sugar level measuring devices for diabetes;
- brace for limb;
- colostomy and ileostomy pads;
- prescription eye glasses and contact lenses;
- crutches;
- diapers, disposable briefs, catheters, catheter trays, tubing or other products required by persons who are incontinent by virtue of illness, injury or affliction;
- heart monitoring or pacing devices;
- hospital bed if required at home;
- needles and syringes;
- wheelchair;
- wigs made for individuals who have suffered abnormal hair loss due to disease, accident or medical treatment;
- power-operated lift designed exclusively for use by disabled individuals to allow them to access different levels of a building or to assist them in gaining access to a vehicle, or to place wheelchairs in or on a vehicle;
- any device designed to assist a person in entering or leaving a bathtub or shower, or getting on or off the toilet;
- devices designed exclusively to enable an individual with a mobility impairment to operate a vehicle;
- any device to aid the hearing of a deaf person, including bone-conduction telephone receivers, extra loud audible signals and devices to permit volume adjustment of telephone equipment above normal levels;
- electronic speech synthesizers that enable mute individuals to communicate using a portable keyboard;
- synthetic speech systems, braille printers and large print-on-screen devices that enable blind persons to utilize computers;
- monitors which can be attached to babies identified as being prone to sudden infant death syndrome (SIDS) and which sound an alarm when the baby stops breathing; and
- hearing aids

Other Eligible Expenses

- premiums paid to a private insurer for medical or hospital coverage, for example Blue Cross premiums;
- the costs of acquisition, care and maintenance (including food and veterinarian care) of a dog specially trained to assist a person who is blind, deaf, or severely impaired in the use of arms or legs;
- costs of arranging and having a bone marrow or organ transplant, including legal fees, insurance premiums, travel, meal and accommodation expenses;
- reasonable home renovations for persons who lack normal physical development or who have severe and prolonged mobility impairment, to enable them to be mobile and functional within the dwelling;
- ambulance fees for transportation to or from hospitals; and
- drugs, substances, and preparations as prescribed by a medical practitioner or dentist and recorded by a licensed pharmacist, including over-the-counter drugs.

Some expenses are not eligible for reimbursement under an HSA

- premiums paid to provincial medical or hospitalization plans;
- medical costs for which the employee is reimbursed or is entitled to be reimbursed (e.g., benefits plan coverage);
- air conditioners (may qualify if medically necessary), humidifiers, dehumidifiers, heat pumps or heat or air exchangers;
- non-prescription birth control devices; and
- antiseptic diaper services.

Guaranteed Critical Illness

New employees and their spouse qualify for \$10,000 of voluntary guaranteed critical illness insurance with no medical evidence if they apply within 90 days after satisfying their benefit waiting period.

See your Benefits Administrator for details and application forms. The insurance company for this insurance is Industrial Alliance Pacific, contract number 100003919.

Optional Critical Illness

Optional Critical Illness Insurance is available through your benefits plan. Employees and their spouse can each apply for Optional Critical Illness insurance in units of \$25,000 to a maximum of 12 units for a total of \$300,000. Regular application procedures apply, medical evidence is required.

The AMSC Critical Illness Insurance Plan, including both Optional and Guaranteed plans, covers the following 25 critical illness and medical conditions:

Alzheimer's Disease	Coronary Artery Bypass Surgery	Major Organ Failure on waiting list*
Aortic Surgery	Deafness	Major Organ Transplant*
Aplastic Anemia	Heart Attack	Motor Neuron Disease**
Bacterial Meningitis	Heart Valve Replacement	Multiple Sclerosis
Benign Brain Tumour	Kidney Failure	Occupational HIV Infection
Blindness	Loss of Independent Existence	Paralysis
Cancer (Life-Threatening)	Loss of Limbs	Parkinson's Disease
Coma	Loss of Speech	Severe Burns
		Stroke

* Replaces Major Organ Failure Requiring Transplant

** Replaces ALS (Lou Gehrig's Disease)

Conversion

If employment terminates before normal retirement date, Employees may convert up to \$100,000 to an individual policy, provided coverage has been in force for at least 24 months. This must be done with 31 days of termination.

The maximum amount available for conversion between the Basic and Voluntary Plan is \$100,000. Spouses are not eligible for the Conversion Benefit.

Optional Life Insurance Coverage

	Employee Optional Life	Spousal Optional Life
Eligibility	All *regular employees and elected officials, provided they are covered under the Basic Group Life Benefit	The spouse of all *regular employees and elected officials, provided the employees are covered under the Basic Group Life Benefit
Benefit Schedule	Can elect coverage in units of \$10,000 to a maximum of 30 units (\$300,000)	Can elect coverage in units of \$10,000 to a maximum of 30 units (\$300,000)
Termination	At employee's 70th birthday	At spouse's 70th birthday
Waiver of Premium	Yes	Spousal Optional Life approved after July 31, 1994, will not include waiver of premium.
Beneficiary	The employee can name any beneficiary of his/her choice	The spouse can name any beneficiary of his/her choice
Conversion Privilege	Yes	Yes, provided the employee is no longer eligible for coverage
Medical Requirements	Applications for Group Optional Life must be completed. The completed application, in most cases, is sufficient for underwriting purposes; however, a full medical examination or additional information regarding medical history may be required.	
Smoking/ Non-Smoking Status	In order to receive and/or maintain non-smoker rates, applicants and participants will be required to declare their smoking or non-smoking status. In the absence of the declaration, the smoker rate will apply.	

*Regular employee means municipal employees who are directly employed by and compensated for services by a participating municipality, while regularly scheduled to work at least 15 hours per week. Returning seasonal employees and volunteer fire/ambulance persons are not eligible to participate.

How to Apply

Complete a Statement of Health (Optional Life Only) form and fax or mail to Sun Life's medical underwriting office in Waterloo, Ontario. The address is on the last page of the application. Approval of this insurance is based on medical evidence and can be denied.

Rates

Following are the monthly rates (effective August 1, 2013) based on the age of the employee or his/her spouse at January 1st each year. Rates are for one unit of \$10,000 and are subject to change.

Age	Male		Female	
	Smoker	Non-Smoker	Smoker	Non-Smoker
to 39	\$0.76	\$0.49	\$0.42	\$0.27
40 - 44	\$1.50	\$0.98	\$1.00	\$0.65
45 - 49	\$2.60	\$1.69	\$1.50	\$0.98
50 - 54	\$4.27	\$2.77	\$2.34	\$1.52
55 - 59	\$7.36	\$4.78	\$4.10	\$2.67
60 - 64	\$12.54	\$8.15	\$6.61	\$4.29
65 - 69	\$20.72	\$13.46	\$10.60	\$6.89

Example of Optional Group Life Insurance Coverage & Monthly Premium

Monthly Premium Example			
	Insurance Amount	Smoker	Non-Smoker
Male	\$50,000	\$3.80	\$2.45
Age 35	\$100,000	\$7.60	\$4.90
Female	\$50,000	\$2.10	\$1.35
Age 35	\$100,000	\$4.20	\$2.70

Beneficiary

Your beneficiary is as designated on your Enrolment Form, or you may choose to designate another beneficiary for this benefit. Should you wish to change your named beneficiary please advise your Benefits Plan Administrator.

You may name any person or persons, estate or institution (except your employer) as your beneficiary. If naming a beneficiary under age 18 years please see your Benefits Administrator for details.

Proof of Claim

If a person dies, proof of claim should be made as soon as possible after the death occurred.

How to Claim

Your Benefits Administrator or your Human Resources Department will provide the claim forms and any assistance required to prepare a claim.

Retiree Benefits Package

Upon retirement (minimum age 55), you can apply for an individual retiree benefits package which includes life, health and dental for you and your dependents. AMSC Insurance bills you directly. The plan terminates at age 70. See your Benefits Administrator for details.