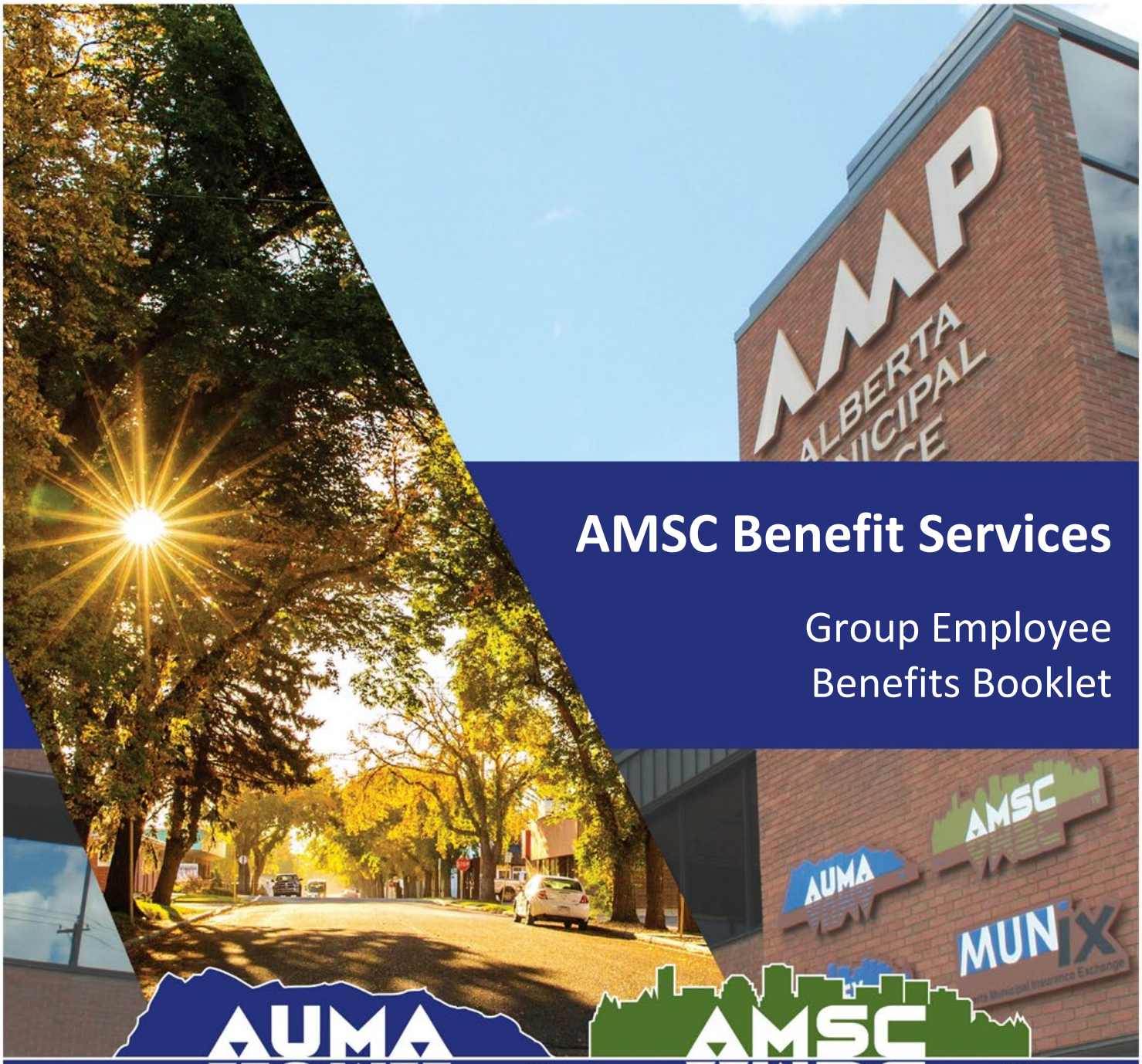

AMSC Benefit Services

Group Employee Benefits Booklet

AUMA™ AMSC™

Lac La Biche County

Regular Municipal Employees and Management

Table of Contents

Benefits Plan Summary

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

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

Management Employees - on the date of hire.

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 Municipal Employees & 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.

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
Each Dependent Child*	$ 5,000

* Dependent children covered from birth to age 21 years or to age 25 years 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 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 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	
Orthodontics (for children only):	50% Reimbursement	$1,500 Lifetime Maximum

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 half the yearly maximum per insured for the balance of the calendar year.

Eligible expenses are payable at the current fee schedule approved by the Dental Association in the employee's province of residence.

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.

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 all eligible 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 Guaranteed Critical Illness in units of $10,000 up to a maximum of $50,000. Dependent children also qualify for either $5,000 or $10,000 of Guaranteed Critical Illness insurance. Medical evidence is not required if application is made within 90 days of the employee 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 for New Employees (no medical required)

As a new employee, AMSC is pleased to offer you the opportunity to apply for Optional Life insurance in units of $10,000 up to a maximum of $30,000 with no medical required. Application must be made within 30 days of the employee satisfying their benefit waiting period.

Optional Life/Spousal Optional Life (medical evidence required)

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. 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.

Eligible Dependents

"Dependent"

A dependent is a spouse or child, who is a resident of Canada and in the case of a child who is a full-time student, the United States. A dependent who is a member on active duty of the armed forces of any country is not eligible for coverage.

"Spouse"

The employee's spouse by marriage or under any other formal union recognized by law, or a person of the opposite sex or of the same sex who is publicly represented as the employee's spouse for at least the last year.

Only one person at a time can be covered as an employee's spouse under this contract.

"Child"

A child, including a stepchild, foster child, legally adopted child or legal ward of the employee or the employee's spouse, who is not married or in any other formal union recognized by law, and who is:

- under age 21, or
- age 21 or over but under age 25 who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) and is entirely dependent on the employee for financial support. Students studying outside Canada must apply in advance of leaving Canada for continuation of all or some benefits.
- attending an apprenticeship training program for 6 weeks during the year does not constitute full-time attendance in an education institution.

A child who becomes handicapped before the limiting age, continues to qualify as long as the child:

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

The employee must provide Sun Life proof of the above within 31 days of the date the child attains the limiting age.

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 newborn 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

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 Age 65 or Over

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.
- **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.
- **Long Term Disability** - Coverage ceases 120 days prior to age 65.
- **Extended Health** - Coverage can continue; however, extended health benefits will be coordinated between the Alberta Health Care Senior Citizens' Blue Cross coverage and they will be the first payers. The balance of eligible claims can be paid for by this plan.
- **Dental Care** - Coverage ceases upon termination of employment or retirement, whichever occurs first.
- **Employee Assistance Program** - Coverage ceases upon termination of employment or retirement, whichever occurs first.
- **Guaranteed & Optional Critical Illness** - Coverage terminates at age 75.
- **Optional Life** - Coverage ceases at age 70.

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

Basic Group Life

Regular Municipal 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.

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.

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 amount of life insurance being extended is subject to any reductions or termination specified by the contract. 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
Each Dependent Child*	$ 5,000

* Dependent children covered from birth to age 21 years or to age 25 years 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.

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 T4A 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 offered to all employees who qualify for Short- or Long-Term Disability.

When you are faced with a serious illness or injury, managing your medical care can be a daunting task. There are so many details to coordinate, treatment options to consider, and decisions to make. A health crisis presents countless choices, and you want to feel confident you are making the right ones. With help from Best Doctors, you can make informed, effective decisions.

As long as you are insured under the AMSC benefit plan, you, your dependents, and your extended family (parents and parent's in law) will have unlimited access to Best Doctor services:

Expert Medical Opinion Have your case reviewed by one of Best Doctors specialists and get a confidential expert report, including recommendations for the best course of action.

Best Doctors 360° ® Get a variety of information that's condition specific, including a website, articles, and community resources that can assist your medical needs.

FindBestDoc™ Best Doctors can help you find a leading specialist in Canada for your medical case or condition.

FindBestCare™ If you need a specialist outside of Canada, Best Doctors can identify one through this service.

Mental Health Navigator is a collaborative mental health service that supports members and their treating providers to enable a more accurate diagnosis, optimal treatment pathway, and better coordination of care to generate better outcomes.

** Best Doctors services are available without charge to all AMSC insured employees and their dependents. Employees are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging.*

ACCESSING BEST DOCTORS SERVICES

If you suspect you have one of the covered conditions, contact Best Doctors at **1-877-419-2378 or online at bestdoctors.com/Canada/start**. Please have your Certificate number ready to identify yourself as an AMSC plan member. When you contract Best Doctors, you will be assigned a Personal Advocate, a dedicated nurse linking you to the doctors reviewing your case. Your Advocate will keep you informed about their progress and answer your questions.

EXPERT MEDICAL OPINION

Best Doctors Expert Medical Opinion is more than just a second opinion; it is a confidential, patented process that complements the care you receive from your own physician by providing a second expert review, bringing greater certainty to your diagnosis and treatment plan. Best Doctors medical specialists perform an in-depth analysis of your medical data, including diagnostic imaging, test results and pathology samples. They provide an expert's detailed summary of the findings, which we encourage you to share with your physician.

The service is designed with two purposes in mind: to reduce the possibility of complications from any misdiagnosis, and help your physician determine your course of treatment.

- You will need to complete a *Release of Medical Information* authorization form in order to start this service. Best Doctors will gather all your medical records on your behalf. Your Personal Advocate will help you throughout the whole process.

- Once Best Doctors receives your complete medical records, your case will be reviewed by a round table of experts affiliated with Harvard Medical School. This team of renowned physicians will create a profile of your case's key issues, ensure all the pertinent questions have been asked about your condition, and define the type of expert (by specialty and focus) needed for your custom consultation.

- Based on the round table's findings, Best Doctors will contact the world leading expert(s) for your medical condition about your case. You will receive an in-depth report that identifies the diagnosis, outlines the most effective treatment protocols, and gives your local treating physician access to Best Doctors for further consultation.

- The entire Expert Medical Opinion process typically takes 7 to 10 days but may require an additional 2 weeks if further medical tests are needed.

Expert Medical Opinion is the most utilized service in the program as it can confirm your diagnosis and helps your treating physician determine the best treatment plan for your condition. In addition, Best Doctors offers the following services.

BEST DOCTOR 360°
Best Doctors can help you get the information you need for a variety of health topics, giving you peace of mind that you're making well-informed decisions about your health care. Whether your condition is simple or complex, Best Doctors will provide you with a variety of tools and resources when you're facing medical uncertainty. These include condition-specific website links, articles and contact information for groups and facilities that can assist you with your medical needs.

FINDBESTDOC
Best Doctors can provide you with a list of surgeons, other specialists and facilities that have the experience to treat your condition.

- A Best Doctors nurse will conduct a search for experts based on your geographic preference. The Best Doctors global database will provide a list of appropriate Best Doctors physicians.

- 3 to 5 business days after your initial request, you will receive a FindBestDoc report. It will include the specialist's professional background, availability, and the information required to see a doctor. Details of the doctors and facilities are taken from Best Doctors database of 50,000 medical specialists throughout the world.

- If you select a Best Doctors physician in Canada, Best Doctors provides the report to your General Practitioner for referral, upon your request. If you select a physician outside of Canada, Best Doctors coordinates all the arrangements.

FINDBESTCARE
If you choose to travel from home to receive treatment, Best Doctors will assist with reservations and accommodations for you and your family. Your Best Doctors Personal Advocate will also provide you with a list of recommended facilities and an estimated cost of treatment.

- **You choose where to go**. Please remember that you must meet your own costs of travel and lodging plus any medical expenses not covered by your provincial or other health care plans. Your use of FindBestCare is conditional on your ability to pay for all such expenses.

- A Best Doctors Personal Advocate will coordinate all medical appointments and a travel itinerary for you. You'll receive travel and medical appointment confirmations as well as a patient welcome kit prior to departure.

- FindBestCare includes even broader personalized services for you and your family if you travel outside Canada for care. Best Doctors will arrange for access to identified medical centres, hospital estimates, pre-admission arrangements, medical appointments, interpreter services, and coordination of enquiries.

- Upon your arrival at the treatment city, a Best Doctors Personal Advocate will contact you and get you ready for the medical appointment, then monitor and coordinate your care with the appropriate physicians. Best Doctors will review relevant information provided by the medical specialists involved in your case and will monitor the treatment process to ensure your medical priorities are being met.

MENTAL HEALTH NAVIGATOR
This concierge styled program is ideal for those who are struggling with a mental health issue and are looking for an expert assessment and treatment recommendation and action plan supported by the navigator.

Expert psychologists and psychiatrists review and often modify the diagnosis and treatment plans made by general practitioners and deliver an action plan for the member to follow.

The navigator provides collaborative ongoing directional support to assist the member with their action plan and journey through the complex mental health system, so members quickly return to wellness.

- Initiate: Members initiate by web or phone
- Intake: Meet with Navigator to gather history, treating physicians and institutions
- Video Consult: Assessment and diagnosis via video
- Review: Navigator coordinates expert review(s) and supports member questions and updates throughout the review
- Results: Expert report and clinical plan are delivered to the member and the member's treating physician.

In healthcare, knowledge saves lives and knowledge is at the core of Best Doctors services. That's why your coverage includes services offered by Best Doctors with its extensive network of over 50,000 doctors, each recognized by peers as a leader. With access to the best medical expertise available today, you are empowered to address your health concerns. Contact Best Doctors toll-free,

1-877-419-2378
Monday-Friday 8am 8pm EST
email: customer.ca@bestdoctors.com
Member portal: www.bestdoctors.com/Canada/start

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 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. Dispensing fee maximums are indicated in the Benefits Plan Summary.

Included medications:

- Vaccines and serums prescribed for preventing illness
- Fertility drugs up to a $2,400 lifetime maximum
- Smoking cessation products and medications up to a $500 lifetime maximum
- Erectile dysfunction medication 50% coverage to an annual maximum of $500 per benefit year

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.

Drug substitution limit – Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

Prior authorization program – The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If a drug that is included in the PA program is prescribed, both the covered person and the attending doctor must complete a prior authorization form. The form will be reviewed to determine if the person will be covered for the drug.

A prior authorization drug list and forms can be found at: mysunlife.ca/priorauthorization

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[3]	$750	No
Naturopath	$750	No
Occupational Therapist	$750	No
Osteopath[2]	$750	No
Physiotherapist	$750	No
Podiatrist/Chiropodist[2]	$750	No
Psychologist/Social Worker[4]	$1,500	No
Psychotherapist/Clinical Counsellor[4]	$1,500	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.
[3] Massage therapists must be an RMT and have the required 2200 hours of education and training.
[4]Licenced psychologists, social workers, psychotherapists and clinical counsellors who are active members of an approved provincial association.

Eye Examinations

Eye exam maximum of $150 per person every 24 months.
See Vision

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 transportation in a licensed ambulance, if medically necessary, for you or your insured dependents **to and from** the nearest hospital that provides the necessary emergency services. Consideration will be given to response charges (where an individual is not transported to a hospital) depending on the circumstances which necessitated the call for an ambulance. 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.

Charges for transportation in a licensed air ambulance, if medically necessary, for you or your insured dependents **to** the nearest hospital that provides the necessary emergency services. Consideration will be given to response charges (where an individual is not transported to a hospital) depending on the circumstances which necessitated the call for an ambulance. 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 provider of the orthotics must employ one of the following specialists (Podiatrist, Chiropodist, Pedorthist, Orthotist, or Chiropractor) on site to dispense custom orthotics and for the claim to be eligible.
- 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;
- 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.
- glucometers, once in any 4 consecutive benefit years for each person.
- insulin pumps and continuous glucose monitors, including sensors and transmitters, up to a combined maximum of $5,000 per person over a period of 3 benefit years.
- cannabis for medical treatment, if the information you and your doctor provide on the Sun Life *Prior Approval Form for Medical Cannabis* meets clinical criteria, including symptoms, for conditions approved by Sun Life. If you submit a claim for medical cannabis and have not been pre-approved, your claim will be declined. Medical cannabis must be dispensed according to Health Canada's regulations. The maximum amount payable is $1,500 per person per benefit year. To obtain Sun Life's *Prior Approval Form for Medical Cannabis*, call the Sun Life Customer Care Centre toll-free at 1-800-361-6212.

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.

Hearing Aids

Charges for the cost and installation of hearing aid(s) and repairs purchased on the written recommendation of a physician. Charges qualify as eligible expenses up to $2,000 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 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 $30,000 in any three consecutive calendar years.

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 and they will be the first payer.

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

You may also go online to submit some paramedical expenses, drug or vision care claims for direct deposit into your bank account. Go to www.mysunlife.ca and click on 'Register Now'.

For claims or coverage inquiries please contact Sun Life at 1-800-361-6212.

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 ALLIANZ GLOBAL 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 to a maximum of $1,000,000 per medical emergency.

About ALLIANZ GLOBAL ASSISTANCE

For more than 50 years, Allianz Global Assistance has supported travelling Canadians when they need it most with value-added travel insurance and assistance services. More than 700 employees support long-term partnerships with some of the best-known brands in the travel and financial services markets. The company also serves as an outsource provider for in-bound call centre services and claims administration for health insurers, property and casualty insurers and credit card companies. Allianz Global Assistance is a specialist brand of Allianz Worldwide Partners for assistance and travel insurance, and is the registered business name for AZGA Service Canada Inc. and AZGA Insurance Agency Canada Ltd. For more information, visit www.allianz-assistance.ca

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 Allianz Global Assistance hotline to establish your claim. *see Limitations.

Medical Assistance

Allianz Global 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. Allianz Global Assistance keeps in touch with the medical situation and may consult the family doctor at home. Allianz Global 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, Allianz Global 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. Allianz Global 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

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

Burial Expenses

If you die while out of the province where you live, Allianz Global Assistance will arrange for all necessary government authorizations and for the return of your remains, 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 Allianz Global Assistance Operations Centre for transmittal. Messages for the patient may be left with Allianz Global Assistance and will be relayed when the patient calls the Hotline.

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

Legal Assistance - Allianz Global Assistance will find a local legal advisor if needed. Allianz Global 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, Allianz Global Assistance will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

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 Allianz Global Assistance is not currently available for various reasons. Call Allianz Global 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.
- Allianz Global Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- The refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

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;
- Contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.

***Note:** Vision coverage is on a rolling 24 months. This means that if you break up the coverage amount into multiple purchases, each purchase carries its own 24 month wait, for example, if your coverage is $350 and you spend $200 on Feb 3, 2017 this $200 will not be available again until Feb 3, 2019 and then if you spend the remaining $150 on Nov 5, 2017 this amount is available on Nov 5, 2019. On the Sun Life website it will always show the latest date, the date that you can utilize the FULL amount again so in this case Nov 5, 2019.*

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.

Adult 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 reasonable and customary charges up to $150. Eye examinations for dependent children under the age of 18 are covered under the provincial health plan.

Note: The eye exam is covered under the extended health care benefit; the expense is not applied 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.

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 Waterloo. 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 or coverage inquiries please contact Sun Life at 1-800-361-6212.

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	
Orthodontics (for children only):	50% Reimbursement	$1,500 Lifetime Maximum

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.

Eligible expenses are payable at the current fee schedule approved by the Dental Association in the employee's province of residence.

Employees whose insurance becomes effective on or after July 1st of any year will be limited to half the yearly maximum 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.

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.

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 re-implantation
- 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
- on-lays

Preventive pins; post and cores

- removal, re-cementation of crowns
- crowns, use of porcelain restricted to teeth 1-6 only
- replacement of crowns and on-lays that are at least 5 years old and cannot be made serviceable
- implant-related crowns
    - Sun Life 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 on-lays; porcelain restricted to teeth 1-6 only
- implant-related bridges
- retentive pins; post and cores, copings
- repair, re-cementation 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 family/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, re-cementation (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, we will not pay more than the reasonable cost of the least expensive alternate procedure. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed.

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 or coverage inquiries please contact Sun Life at 1-800-361-6212.

Pre-determination of Dental Treatment

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.

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 healthy 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

LifeSpeak on Demand

Life Speak 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:

- 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

***Watch** by logging into: http://AMSC.lifespeak.com Corporate ID: **lifespeak**

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.

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;
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye;
- 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 in 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 Guaranteed Critical Illness in units of $10,000 up to a maximum of $50,000. Dependent children also qualify for either $5,000 or $10,000 of Guaranteed Critical Illness insurance. Medical evidence is not required if application is made within 90 days of the employee 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.

Employee and Spouse Critical Illness Insurance *Premium Rates per $10,000*				
	Male		**Female**	
Age	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**
Under 25	$1.06	$1.52	$1.08	$1.48
25 - 29	$1.42	$2.38	$1.48	$2.44
30 - 34	$1.78	$3.20	$1.84	$3.52
35 - 39	$2.16	$4.18	$2.24	$4.38
40 - 44	$3.02	$6.44	$3.28	$6.38
45 - 49	$4.60	$10.76	$4.98	$9.94
50 - 54	$6.88	$17.90	$7.12	$15.26
55 - 59	$9.44	$26.78	$9.36	$23.24
60 - 64	$15.84	$43.50	$15.14	$32.78
65 – 69	$23.28	$66.30	$23.08	$50.92
70 - 74	$46.38	$106.48	$33.00	$73.90

Dependent Children Critical Illness Insurance *Monthly Premium for All Eligible Children*	
Benefit Amount	**Monthly Premium**
$5,000.00	$1.95
$10,000.00	$3.90

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

* Replaces Major Organ Failure Requiring Transplant
** Replaces ALS (Lou Gehrig's Disease)

Conversion

If employment terminates before normal retirement date, Employees/Spouses 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 for New Employees (no medical required)

New employees can apply for $10,000, $20,000 or $30,000 of Optional Life with no medical required. To be eligible for this benefit the application must be made within 30 days of the employee satisfying their benefit waiting period.

How to Apply

The employee completes the My Enrolment Form - Optional Life Insurance, and gives the completed form to their Benefits Administrator or Human Resources Department.

Rates / Beneficiary / Proof of Claim / How to Claim

The rates are the same as the regular Optional Life, see rated listed below. Information on Beneficiary, Proof of Claim and How to Claim is also the same as indicated below for the regular Optional Life benefit.

Optional Life Insurance Coverage (medical evidence required)

	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 the first of the month following his/her birthday. Rates are for one unit of $10,000 and are subject to change.

	Male		Female	
Age	**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 individual retiree benefits packages which include life, health and dental for you and your dependents. See your Benefits Administrator for details.