myBenefits

THE POWER TO CHOOSE

An effective benefits program for eligible full-time and regular part-time employees at Candu

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SNC·LAVALIN

Candu®

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What's inside

The power to choose

At Candu, we know the importance of your benefits program and the value of the financial security it offers. We also understand that choice alone doesn't ensure success. To be truly effective, a benefits program must:

- address the specific needs of a changing and increasingly diverse workforce;
- offer relevant financial protection; and
- be meaningful, affordable and sustainable.

In short... one program, many choices.

That's where the *myBenefits* program comes in. A key part of your Total Compensation package, the program gives you access to competitive and affordable benefits. Even better, it puts added control in your hands. You have the power to choose the benefits that matter most to you and your family.

This booklet is designed to help you do just that. It provides a comprehensive overview of the various options available to you through the *myBenefits* program. More specifically:

1. **It will help you make informed benefit selections.** Which benefit choices give you and your family the protection you want … and need?
2. **It will help you compare coverage** under the *myBenefits* program against coverage available outside the program (e.g., under your spouse's/partner's plan).
3. **It will serve as an easy reference guide.** It will help you determine, for example, what you can and cannot claim under the various benefit choices.

We suggest that you review this booklet carefully before making your benefit choices. We also suggest that you keep it for future reference.

The *myBenefits* program is designed to help meet your benefit needs throughout what we hope will be a rewarding career with Candu. To take full advantage of this program, however, you need to make some important decisions.

Our starting points

The *myBenefits* program gives you the power to choose benefits coverage that serves your specific needs and preferences. Just as important, it gives you the flexibility to update your benefit selections every two years – so that the program continues to meet your changing needs and circumstances.

Bottom line: your *myBenefits* program is all about your power to choose. In addition to a range of company-paid core benefits and optional coverages, *myBenefits* gives you an opportunity to select your preferred health and dental coverage from a range of benefit options. As illustrated below, you can:

- choose a competitive Base Option that provides a wide range of health and dental coverage, or
- choose to "Buy Up," "Buy Different," or "Buy Down," depending on your personal needs.

The choice is yours!

Option 4 – Buy Up

- Offers you enhanced levels of health and dental coverage – and is designed for employees who have above-average health and/or dental needs, or are looking for added protection.
- This Buy-Up option costs more than Option 1, but gives you more comprehensive coverage in return.

Option 1 – Base Option

- Offers a broad level of health and dental coverage.
- Under this option, Candu pays 100% of the total premiums for Travel and Dental coverage and 75% of the Extended Health Care premium. The remaining 25% of the health care premium is paid by you.

Option 2 – Buy Different

- Offers you comparable coverage to the Base Option – but added control over how your benefit dollars are spent.
- It includes a tax-effective Health Care Spending Account (HCSA) that will help cover a number of services and procedures not provided under Option 1.
- Your cost for Option 2 is slightly lower than Option 1.

Option 3 – Buy Down

- Offers a basic level of coverage – and is designed for employees with limited health and/or dental needs (or coverage available outside of Candu through a spouse's/partner's plan).
- Candu pays the full cost of Long Term Disability coverage.
- Your premium cost is $0 – the company covers the full cost of this option.

Benefit highlights

Following is a quick-reference summary of the core and optional benefits available under the *myBenefits* program. This is a high-level summary only. For a more detailed description of each benefit, please refer to the appropriate section of the booklet.

Your *myBenefits* options

Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Extended Health Care*				
Drugs				
▪ Prescription drugs	▪ 100% of eligible prescription drugs ▪ Mandatory Generic substitution	▪ 90% of eligible prescription drugs up to the out-of pocket maximum, and 100% thereafter ▪ Mandatory Generic substitution	▪ 80% of eligible prescription drugs up to the out-of pocket maximum, and 100% thereafter ▪ Mandatory Generic substitution	▪ 100% of eligible prescription drugs ▪ Mandatory Generic substitution
▪ Out-of-pocket maximum for drugs	Not applicable	$1,500 per person per calendar year	$3,000 per person per calendar year	Not applicable
▪ Over-the-counter prescription drugs	Excluded, except for life-sustaining drugs	Excluded, except for life-sustaining drugs	Excluded, except for life-sustaining drugs	Excluded, except for life-sustaining drugs
▪ Calendar year deductible for drugs	▪ $25 per person ▪ $50 per family	None	None	None
▪ Dispensing fee cap	$8.00 per prescription	$8.00 per prescription	$7.00 per prescription	$10.00 per prescription
Paramedical services	Based on a schedule for each of a specified services list, per person, per calendar year: ▪ Physiotherapist/ Athletic therapist: $1,000 ▪ Massage therapist: $400 ▪ Chiropractor: $400 ▪ Psychologist: $35 first visit, $20/hr subsequent to max. $1,000 ▪ Speech therapist: $30/hr to max. $500 ▪ Osteopath or Chiropodist: $100 plus $25 for related x-rays ▪ Podiatrist: $100 plus $25 for related x-rays ▪ Naturopath: $200	Up to a combined calendar year max. of $1,000 per person for the same services list as Option 1, plus additional services of: ▪ Nutritionist/ Dietitian ▪ Acupuncturist	Annual $200 max. for each of the same services list as Option 1, per person per calendar year	Up to a combined calendar year max. of $1,500 per person for the same services list as Option 1, plus additional services of: ▪ Nutritionist/ Dietitian ▪ Acupuncturist
Vision care	$500 per person over 24 months	$400 per person over 24 months	$250 per person over 24 months	$500 per person over 24 months

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*Unless indicated otherwise, the plan reimburses 100% of eligible expenses up to specified maximums.

Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Hospital	Semi-private	Semi-private	Ward coverage under the provincial hospital plan	Semi-private
Private-duty nursing	Unlimited	Up to $10,000 per person, per calendar year	Not covered	Unlimited
Premium sharing	▪ Candu pays 75% ▪ You pay 25%	▪ Candu pays 75% ▪ You pay 25%	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays the same dollar amount as under Option 1 ▪ You pay the difference in total premium cost
Travel				
Out-of-country emergency medical	For first 60 days of travel	For first 60 days of travel	For first 60 days of travel	For first 60 days of travel
Premium sharing	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0
Dental care				
Basic services	▪ 80% ▪ calendar year max: unlimited	▪ 80% ▪ calendar year max: unlimited	▪ 80% ▪ calendar year max: unlimited	▪ 100% ▪ calendar year max: unlimited
Major restorative services	▪ 75% ▪ calendar year max: $1,250 per person	▪ 75% ▪ calendar year max: $1,250 per person	▪ 75% ▪ calendar year max: $1,250 per person	▪ 75% ▪ calendar year max: $2,000 per person
Orthodontia	50% of eligible services, to a lifetime max. of $3,000	50% of eligible services, to a lifetime max. of $3,000	Not applicable	50% of eligible services, to a lifetime max. of $3,000
Premium sharing*	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays the same dollar amount as under Option 1 ▪ You pay the difference in total premium cost
Health Care Spending Account				
Health Care Spending Account	Not applicable	▪ $200 single ▪ $400 family ▪ Can use money in your account to purchase a wide range of medical and/or dental services and procedures (to the extent that they are not covered under Option 2) ▪ Allows you to pay for these services using pre-tax dollars	Not applicable	Not applicable
Basic Life Insurance				
Benefit	1 times annual earnings	1 times annual earnings	1 times annual earnings	1 times annual earnings
Premium sharing	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0
Supplementary Life Insurance				
Benefit	1 times annual earnings	1 times annual earnings	▪ Coverage optional ▪ 1 times annual earnings	1 times annual earnings
Premium sharing	▪ Candu pays 1/6th ▪ You pay 5/6^{ths}	▪ Candu pays 1/6th ▪ You pay 5/6^{ths}	▪ You pay 100%	▪ Candu pays 1/6th ▪ You pay 5/6^{ths}

*Regular part-time employees (working less than 80% of full-time work schedule) will pay an additional premium for Dental Plan coverage, except under Option 3 – Buy Down.

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Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Long Term Disability				
Benefit	▪ 66⅔% of base earnings to a monthly maximum of $24,000 without evidence of insurability (EOI), and $28,000 with EOI ▪ Cost-of-living increases to a maximum of 4%	▪ 66⅔% of base earnings to a monthly maximum of $24,000 without evidence of insurability (EOI), and $28,000 with EOI ▪ Cost-of-living increases to a maximum of 4%	▪ 66⅔% of base earnings to a monthly maximum of $24,000 without evidence of insurability (EOI), and $28,000 with EOI ▪ Cost-of-living increases to a maximum of 4%	▪ 66⅔% of base earnings to a monthly maximum of $24,000 without evidence of insurability (EOI), and $28,000 with EOI ▪ Cost-of-living increases to a maximum of 4%
Taxes	Benefit payments are taxable as income	Benefit payments are taxable as income	Benefit payments are taxable as income	Benefit payments are taxable as income
Opt-out	May waive coverage with 25 years or more of pensionable service	May waive coverage with 25 years or more of pensionable service	May waive coverage with 25 years or more of pensionable service	May waive coverage with 25 years or more of pensionable service
Premium sharing	▪ Candu pays 50% ▪ You pay 50%	▪ Candu pays 50% ▪ You pay 50%	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 50% ▪ You pay 50%

Your Optional Insurance

Options	Coverage
Optional Group Life Insurance & Accident Insurance	
Employee	▪ Units of $10,000 to a maximum of $250,000 ▪ Can select Optional Group Life only, or Optional Group Life with Accident Insurance ▪ If Accident Insurance is selected, coverage amount is equal to Optional Group Life
Spouse/partner	▪ Units of $10,000 to a maximum of $250,000 ▪ Can select Optional Group Life only, or Optional Group Life with Accident Insurance ▪ If Accident Insurance is selected, coverage amount is equal to Optional Group Life
Premium sharing	▪ You pay 100%
Optional Critical Illness Insurance	
Employee	▪ Units of $10,000 to a maximum of $150,000 ▪ Up to $20,000 coverage without evidence of good health ▪ Benefit is tax-free and payable to you (employee)
Spouse/partner	▪ Units of $10,000 to a maximum of $150,000 ▪ Up to $20,000 coverage without evidence of good health ▪ Benefit is tax-free and payable to you (employee)
Premium sharing	▪ You pay 100%

The *myBenefits* benefit period runs for two years from January 1st of the first calendar year to December 31st of the second calendar year. For Optional Insurance, you may enroll or cancel at any time, not only at re-enrollment.

Important information

Eligibility

You are eligible to participate in the *myBenefits* program if you are an active employee of Candu, and are either:

- a continuous full-time employee who works 37.5 hours per week; or
- a regular part-time employee who works a minimum of 15 hours per week;

and,

- a resident of Canada; or
- a resident of Canada who is temporarily assigned outside Canada, and full contributions are being made on your behalf to keep your government pension plan and/or government health insurance plan (or equivalent plan) in force.

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

If both an employee and such employee's spouse are employees of the Company, then they must at the time of becoming eligible for insurance under this policy, elect for one spouse to be considered an employee and the other as being the dependent of such employee.

Spouse/partner is defined as:	The person of the same or opposite sex who is either: ▪ legally married to you through an ecclesiastical or civil ceremony; or ▪ has been continuously cohabitating with you in a conjugal relationship for at least one year and who you publicly represent as your spouse/partner. The term conjugal relationship includes conjugal relationships between partners of the same sex.

Dependent children are defined as:	A natural or adopted child, step-child or foster child of you and/or your spouse/partner who is unmarried, and is:
	▪ under age 21; or if a full-time student, is:
	  • under 26 for Quebec residents; or
	  • under age 25 for residents of other provinces;
	▪ not employed on a full-time basis; and
	▪ not eligible for coverage as an employee under this or any other group benefits program; or
	▪ any age, with pre-approval of the plan administrator, if the child is incapacitated on the date he or she reaches the age when coverage would normally terminate and was covered under this benefits program immediately prior to that date. A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on you for support, maintenance and care, due to a mental or physical disability.

Coverage for your spouse/partner and/or a dependent child will stop as soon as he or she fails to satisfy the applicable definition. For example, a child will no longer qualify for coverage if he or she gets married, starts full-time employment, or exceeds the established age limits.

Default coverage

Your first year

For new employees enrolling in the *myBenefits* program for the first time, but who do not enroll within **31 days of their benefit eligibility date**, the following default coverage will apply:

Option 1 - Base Option, including:

- Option 1 Extended Health Care coverage;
- Option 1 Travel coverage;
- Option 1 Dental coverage;
- Basic and Supplementary Life Insurance coverage; and
- Long Term Disability Insurance (for full-time and regular part-time employees working at 80% of full-time schedule).

Unless you experience a qualifying life event (*see page 8 for details*), your default coverage under Option 1 – the Base Option, will remain in effect until the next bi-annual re-enrollment period. You can apply for coverage under the Optional Group Life & Accident, and Critical Illness Insurance Plans at *any time* by completing the appropriate forms and supporting documents. Contact your local Human Resources department for more information.

Future changes

You may elect to update your benefit options during the re-enrollment periods held every two years. If you choose not to update your benefit options during the bi-annual re-enrollment period, your current benefit coverage will remain in effect for the following two-year period. Again, you won't be able to change your coverage until the next re-enrollment – unless you experience a qualifying life event (*see page 8 for details*).

Covering your family

Benefit plans are not just about you; they are also about your family. That's why the *myBenefits* program allows you to extend coverage to your family under the Extended Health Care (EHC), Travel, Dental, Group Life & Accident, and Critical Illness benefit plans. For all levels of coverage, you can select the class of coverage that fits your family circumstances.

Under the EHC, Travel and Dental Plans, there are two different classes of coverage:

- **Employee only** – Only you will be covered.
- **Family** – You, your spouse/partner and/or eligible dependent children will be covered.

As you might expect, the annual cost of family coverage will be higher than employee-only coverage. You can elect a different class of coverage for each plan. However, if you live in Quebec, the law requires that you select a minimum level of drug coverage for you and your eligible dependents (i.e., coverage that is RAMQ-compliant), unless you have comparable coverage under another plan. If you select an option that provides less than the minimum level of drug coverage, you may be asked to acknowledge that you have RAMQ-equivalent coverage under another plan.

Re-enrollment

As a member of the *myBenefits* program, you will be given an opportunity to change your health care and dental choices effective January 1st every two years. Generally speaking, the selections you make during this bi-annual enrollment period will remain in effect for a full two-year benefit period.

Qualifying life event

You may change your benefit options part-way through the two-year benefit period if you experience what is known as a "qualifying life event." This is an event that requires you to change your chosen benefit coverage status under the Health and Dental Plans (e.g., single to family or vice versa).

Eligible life events include:

- a marriage, separation or divorce;
- the birth or adoption of a child;
- the death of a spouse/partner or child;
- a child over 21 returning to school full-time (you can increase from single to family coverage only);
- dependent children no longer qualifying for coverage (you can decrease from family to single coverage only); and
- the loss of group benefits coverage under your spouse's/partner's plan (e.g., due to a change in your spouse's/partner's employment).

If you wish to change your benefits coverage, you must do so **within 31 days of your qualifying life event**. You can change your coverage by contacting Human Resources.

If you miss this 31-day window, your current selections will remain in effect for the remainder of the two-year benefit period. Remember, you will be given an opportunity to update your benefit selections during the next re-enrollment period.

Evidence of insurability (EOI)

Depending on the selections you make under the *myBenefits* program, you (and/or your spouse/partner) may be required to provide evidence of insurability (EOI) before your coverage can take effect. In other words, you will have to submit a statement of health or medical questionnaire form to the insurer providing information on your state of health. Further medical evidence may be requested by the insurer.

EOI is also required when you apply for insurance in excess of the non-evidence limit. EOI requirements are outlined in the following table.

When is EOI required?

New employee
▪ Long Term Disability – **all benefits amounts in excess of $24,000/month**
▪ Optional Group Life & Accident Insurance – Employee and spouse/partner – **all benefits amounts**
▪ Critical Illness Insurance – Employee and spouse/partner – **all benefits amounts in excess of $20,000**
As an active employee
▪ Supplementary Life Insurance – **when applying for coverage more than 31 days after the date you first became eligible, or in all cases if reapplying for coverage after having dropped coverage under Option 3 – Buy Down.**
▪ Long Term Disability – **all increased benefits coverage in excess of $24,000/month**
▪ Optional Group Life & Accident Insurance – Employee and spouse/partner – **any new or increased benefits coverage**
▪ Critical Illness Insurance – Employee and spouse/partner – **any new or increased benefits coverage in excess of $20,000**

Any coverage for which you are required to submit EOI will **not** go into effect until your EOI has been approved by the insurer providing the coverage. Whether or not your EOI is approved is the exclusive decision of the insurer – Candu has no say one way or the other.

Premium deductions based on the higher level of coverage will take effect once your EOI has been approved.

Beneficiaries

You can name one or more beneficiaries for your Basic Life and Supplementary Life insurances, as well as any Optional Group Life Insurance and Accident Insurance. When designating your beneficiary, keep in mind the following:

If you appoint multiple beneficiaries…

- If you appoint more than one person as beneficiary for the same benefit, you must specify what percentage of the benefit each will receive; the total must add up to 100%.

If you want to appoint minor beneficiaries…

- If you name a minor as a beneficiary, he or she will not have access to any benefit payout until reaching the age of majority – unless you take the necessary legal steps before your death. Those steps vary from province to province. You must name a trustee for a minor beneficiary. Before naming a minor as beneficiary, you may wish to seek legal assistance.

If you live in Quebec…

- Under Quebec law, if you designate your legally married or civil union spouse/partner as beneficiary, this designation will be irrevocable unless you specify that it is revocable. If you specify that a designation is revocable, you can change your beneficiary at any time without the consent of your spouse/partner. To change an irrevocable designation, you will need the written consent of your spouse/partner.

You are automatically the beneficiary for any Critical Illness Insurance payable, including payment for coverage on your spouse/partner. Any benefit payable after your death would be made to your estate.

A beneficiary designation form is available online at the *myBenefits* web page on the Candu intranet, or by contacting Human Resources.

Eligibility for health and dental expenses

Eligible health and dental expenses will only be covered to the extent that:

- they are medically necessary,
- reasonable and customary (as determined by the insurer based on industry standards),
- recommended by a physician or dentist (as appropriate), and
- not covered under the provincial medical plan or any other government-sponsored program.

Different tax treatment for Quebec residents

In 1993, the Quebec provincial government imposed a provincial tax on employer-paid medical, drug, dental and accident benefits for workers living in that province. As such, benefits programs are taxed differently for employees living in Quebec versus other provinces.

If you live in Quebec, you will incur a taxable benefit, for provincial income tax purposes, for any claims paid from your Health Care Spending Account (Option 2). Under current tax legislation, you will not pay federal tax, but Quebec provincial tax will apply.

Coordinating claims

If both you and your dependents are insured for similar benefits under another plan, you can coordinate your claims with both the *myBenefits* program and the other plan. In other words, you can claim payment for health or dental expenses under both plans, and receive payment for up to 100% of your expense. If your spouse's/partner's benefit plan includes provisions for coordination, this is typically governed by industry guidelines, as follows:

- You must first submit claims for yourself through the *myBenefits* program. Any unpaid personal claims can then be submitted through your spouse's/partner's plan.
- Your spouse/partner must submit personal claims through his or her group plan first. If that plan doesn't cover the full cost of the service or procedure, you can claim the remaining expense through the *myBenefits* program.

Claims for dependent children are to be submitted first to the plan of the parent whose birthday falls earlier in the year. If you were born in March, for example, and your spouse/partner was born in July, you would submit claims for dependent children to the *myBenefits* program first. Again, any remaining expenses should, in turn, be submitted to your spouse's/partner's plan as a secondary payer.

In situations where you and your spouse/partner are separated or divorced, you should seek reimbursement from benefit plans according to the following order:

- the plan of the parent with custody of the child,
- the plan of the spouse/partner of the parent with custody,
- the plan of the parent without custody,
- the plan of the spouse/partner of the parent without custody.

In situations where you belong to two or more separate plans (e.g., you or your spouse/partner are an employee at two organizations and have coverage at both), your claims should be submitted in the following order:

- the plan where you are an active full-time employee,
- the plan where you are an active part-time employee,
- the plan where you are a retiree.

In no case can the total reimbursement you (and your spouse/partner) receive exceed 100% of the actual expenses you (or your spouse/partner) have incurred. With that in mind, you might want to consider minimizing your health and/or dental coverage under the *myBenefits* program if you have coverage under another plan. Minimizing your coverage may make sense if the cost of coverage under the *myBenefits* program would not warrant the additional amounts you can claim on a coordinated basis.

In situations where your coverage is provided through a Health Care Spending Account and your spouse/partner has health coverage, you would first submit your expense claim to your spouse's/partner's plan, and then submit the remaining expense to your Health Care Spending Account. Keep in mind that in no case can the total reimbursement you (and your spouse/partner) receive exceed 100% of the actual expenses you have incurred.

If you are on an approved leave

You may, with the approval of the company and the carrier, continue some coverage while on an approved leave of absence. Depending on the reason for your leave, you may be required to pay the full cost of your coverage.

While you are on a leave of absence, your benefit coverage will remain unchanged. Under the *myBenefits* program, the coverage you elected at the last enrollment prior to the commencement of your leave will remain in place until the end of your leave, and your benefit levels cannot be increased.

If you are on maternity or parental leave

Your coverage will continue under the *myBenefits* program while you are on an approved maternity or parental leave. You will be required to pay your share of the premium cost, where applicable.

If you already have family coverage and you want to add a new dependent to your list of covered dependents under the Extended Health Care, Travel and Dental Plans, you must do so within 31 days of their birth or adoption. If you did not already have family coverage and you want to elect coverage for your new child, you must do so within 31 days of their birth or adoption. Because this is considered a qualifying life event, you will be allowed to review and change your *myBenefits* options.

If you miss any of these windows, your coverage will remain unchanged and in effect until the next re-enrollment period.

Effective date

Benefit coverage under the *myBenefits* program is effective on the first day of the two-year benefit period – typically January 1st of year one, and runs until December 31st of year two (e.g., January 1, 2016 to December 31, 2017). For employees enrolling for the first time, coverage begins on your first day of eligible employment.

Any coverage for which evidence of insurability (EOI) is required will not go into effect until the date the EOI is approved by the insurer. In the case of Critical Illness Insurance, coverage will take effect on the first day of the month following the date of approval by the insurer.

Once approval is received, your insurance premiums will be adjusted to reflect the new coverage amount.

Termination of coverage

Your coverage under the *myBenefits* program will end on the earliest of:

- the date you cease to be an eligible employee for Life and Long Term Disability, and on the first day of the month following the date you cease to be an eligible employee for Extended Health Care, Travel and Dental;
- the date you cease to be actively at work, unless the benefit contracts allow for your coverage to be extended beyond this date;
- the date you enter the armed forces of any country on a full-time basis;
- the date the benefit contracts terminate or coverage on the class to which you belong terminates; or
- the date you reach the termination age specified for each benefit.

There are a couple of exceptions to when your *myBenefits* coverage will end, as follows:

- If you retire on the last day of the month, your Extended Health Care and Travel coverage for you and your dependents will end on the last day of the following month.
- If you were to die on the last day of the month, Extended Health Care, Travel and Dental coverage for your dependents will end on the last day of the following month.

Your dependent's coverage terminates on the date your coverage terminates, or the date your dependent ceases to be an eligible dependent, whichever is earlier.

Extended Health Care, Travel and Dental coverage for a dependent child who graduates from an accredited institute of learning, provided all other eligibility requirements are satisfied, will continue until the earlier of August 31st or March 31st coincident with or immediately following graduation.

Health Care Plans

There are few things in this world more important than our physical and mental well-being. With that in mind, the *myBenefits* program offers three important and health-related plans:

- an **Extended Health Care Plan**, including prescription drugs;
- a **Travel Plan**, including out-of-province/country emergency medical coverage;
- a **Dental Plan**.

The amount of coverage you receive under each of these three key plans – and the amount you will pay for your coverage – depends on which option you select, as summarized in the table below.

Your *myBenefits* Extended Health Care, Travel and Dental Options

Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Extended Health Care[1]				
Drugs				
▪ Prescription drugs	▪ 100% of eligible prescription drugs ▪ Mandatory Generic substitution	▪ 90% of eligible prescription drugs up to the out-of-pocket maximum, and 100% thereafter ▪ Mandatory Generic substitution	▪ 80% of eligible prescription drugs up to the out-of - pocket maximum, and 100% thereafter ▪ Mandatory Generic substitution	▪ 100% of eligible prescription drugs ▪ Mandatory Generic substitution
▪ Out-of-pocket maximum for drugs	Not applicable	$1,500 per person, per calendar year	$3,000 per person, per calendar year	Not applicable
▪ Over-the-counter prescription drugs	Excluded, except for life-sustaining drugs	Excluded, except for life-sustaining drugs	Excluded, except for life-sustaining drugs	Excluded, except for life-sustaining drugs
▪ Calendar year deductible for drugs	▪ $25 per person ▪ $50 per family	None	None	None
▪ Dispensing fee cap	$8.00 per prescription	$8.00 per prescription	$7.00 per prescription	$10.00 per prescription

Unless specified otherwise, the Extended Health Care Plan reimburses 100% of eligible expenses up to the specified maximum.

Table continues on the next page

Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Paramedical services	Based on a schedule for each of a specified services list, per person, per calendar year: ▪ Physiotherapist/ Athletic therapist: $1,000 ▪ Massage therapist: $400 ▪ Chiropractor: $400 ▪ Psychologist: $35 first visit, $20/hr subsequent to max. $1,000 ▪ Speech therapist: $30/hr to max. $500 ▪ Osteopath or Chiropodist: $100 plus $25 for related x-rays ▪ Podiatrist: $100 plus $25 for related x-rays ▪ Naturopath: $200	Up to a combined calendar year max. of $1,000 per person for the same services list as Option 1, plus additional services of: ▪ Nutritionist/ Dietitian ▪ Acupuncturist	Annual $200 max. for each of the same services list as Option 1, per person, per calendar year	Up to a combined calendar year max. of $1,500 per person for the same services list as Option 1, plus additional services of: ▪ Nutritionist/ Dietitian ▪ Acupuncturist
Vision care	$500 per person over 24 months	$400 per person over 24 months	$250 per person over 24 months	$500 per person over 24 months
Hospital	Semi-private	Semi-private	Ward coverage under the provincial hospital plan	Semi-private
Private-duty nursing	Unlimited	Up to $10,000 per person, per calendar year	Not covered	Unlimited
Premium sharing	▪ Candu pays 75% ▪ You pay 25%	▪ Candu pays 75% ▪ You pay 25%	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays the same dollar amount as under Option 1 ▪ You pay the difference in total premium cost
Travel				
Out-of-country emergency medical	For first 60 days of travel	For first 60 days of travel	For first 60 days of travel	For first 60 days of travel
Premium sharing	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0
Dental care				
Basic services	▪ 80% ▪ calendar year max: unlimited	▪ 80% ▪ calendar year max: unlimited	▪ 80% ▪ calendar year max: unlimited	▪ 100% ▪ calendar year max: unlimited
Major restorative services	▪ 75% ▪ calendar year max: $1,250 per person	▪ 75% ▪ calendar year max: $1,250 per person	▪ 75% ▪ calendar year max: $1,250 per person	▪ 75% ▪ calendar year max: $2,000 per person
Orthodontia	▪ 50% of eligible services, to a lifetime max. of $3,000	▪ 50% of eligible services, to a lifetime max. of $3,000	▪ Not applicable	▪ 50% of eligible services, to a lifetime max. of $3,000
Premium sharing	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays the same dollar amount as under Option 1 ▪ You pay the difference in total premium cost

Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Health Care Spending Account				
Health Care Spending Account	Not applicable	▪ $200 single ▪ $400 family ▪ Can use money in your account to purchase a wide range of medical and/or dental services and procedures (to the extent that they are not covered under Option 2) ▪ Allows you to pay for these services using pre-tax dollars	Not applicable	Not applicable

Important notes

Please note that your Extended Health Care (EHC), Travel and Dental options are linked under the *myBenefits* program. If you select Option 3 under the Health Plan, for example, you will automatically get coverage under Option 3 of the Dental Plan. Coverage under the Travel Plan is the same under all four options.

Depending on your needs and preferences, however, you can select different "classes" of coverage (single or family) under your preferred Health and Dental options. For example, you can select family coverage under your Health option and single coverage under the Dental option (or vice versa). As you might expect, family coverage will cost more in each case.

Your coverage under the Travel Plan is linked to your coverage under the EHC Plan. If you select single coverage under EHC, your Travel coverage will also be single.

Coverage under the *myBenefits* program is mandatory unless you can demonstrate that you have comparable coverage available from another arrangement – typically a spouse's/partner's plan. If you do have alternative coverage – and you elect to opt out of the *myBenefits* Health and Dental Plans – you will automatically receive single coverage under the Travel Plan, at no cost to you.

Extended Health Care Plan

Provincial health plans provide your first line of defense against medical expenses. These plans typically cover a range of medical items, services and supplies, including:

- doctors' and surgeons' fees;
- specialists' fees when referred by a general practitioner;
- diagnostic procedures, including x-rays and lab tests;
- prenatal and maternity care;
- standard ward accommodation;
- outpatient treatment; and
- other services.

Please note that changes to provincial health plans, the introduction of new medical and dental services, or the development of new prescription drugs will not result in an automatic adjustment to your *myBenefits* program. Candu will continue to monitor the benefits program to determine what, if any, adjustments are required.

Your options

The *myBenefits* Extended Health Care Plan (EHC) allows you to augment the important coverage provided through your provincial health plan, based on your personal needs and circumstances.

As outlined in the table in the previous pages, you have four levels of coverage to choose from. You can also elect (1) single coverage (for you alone) or (2) family coverage, which extends benefits to your spouse/partner and/or eligible dependent children.

Eligible expenses

Following is a summary of the individual health benefits covered under your *myBenefits* program. The actual amount of coverage you receive, if any, will depend on the health care option you select, as summarized in the table starting on page 12.

Please note that to qualify for reimbursement under the *myBenefits* program, medical services and procedures must be:

- medically necessary;
- reasonable and customary; and
- recommended by a qualified physician (except for professional services, unless otherwise specified, and ManuAssist expenses).

Prescription drugs

The *myBenefits* EHC Plan covers all prescribed drugs, including the following items:

- Drugs, sera and injectables available only on a prescription* by a physician or dentist and dispensed by a pharmacist, dentist or physician. Fertility drugs are subject to a lifetime maximum of $15,000 per person.

  *Those drugs that legally require a written prescription in order to be purchased.
- Oral contraceptives, intrauterine devices and diaphragms.
- All benefit options cover prescribed over-the-counter drugs that are life sustaining and will continue to cover drugs and supplies required as a result of a colostomy or ileostomy and/or for the treatment of cystic fibrosis, diabetes, parkinsonism or heart disease.

Your reimbursement under all four *myBenefits* options is subject to a generic drug pricing limitation. That means wherever an interchangeable generic drug is available, but not dispensed, your eligible expense will be limited to the lowest cost suitable generic drug. However, this limitation does not apply to any prescription written by brand name where an appeal has been submitted to Sun Life and approved.

What prescription expenses are not covered

The *myBenefits* program does not pay any benefit or accept liability for claims relating to:

- anti-smoking or smoking cessation drugs;
- vitamins (other than injected vitamins);
- vitamin and mineral preparations; and
- food supplements.

Sun Life Benefit Card

By presenting your Sun Life Benefit Card at the time of purchase for your prescription drugs, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of your prescription. The card will be honoured by pharmacists who accept the Pay Direct drug card.

To fill a prescription for a covered drug expense, you will:

- present the Sun Life Benefit Card to the pharmacist at the time of purchase; and
- pay any amounts that are not covered under this benefit plan (e.g., the dispensing fee above the capped amount).

You will be required to pay the full cost of the prescription at the time of purchase if:

- your pharmacy does not participate in the Pay Direct card program; or
- you do not have your card with you at the time of purchase; or
- the prescription is not payable through the Pay Direct card program (in which case, Sun Life Financial's Customer Service department can be contacted for direct support).

Hospital / health care facilities

The EHC Plan covers the difference between the public ward allowance under your provincial health plan and the cost of semi-private accommodation in a hospital, except under Option 3 – the Buy-Down option. Coverage is from the first day of your hospital stay.

The plan will cover your hospital expenses incurred as an out-patient for necessary medical or surgical treatment, excluding physicians' fees, and special nurses' fees.

The plan will also cover your cost for room, board and normal nursing care provided in a licensed nursing home (for chronic care, but excluding convalescent and custodial care), up to $10 per day for 120 days during any period of 12 consecutive months.

Accidental dental

The plan covers treatment for an accidental injury to natural teeth or jaw resulting from an external blow. Treatment must commence within 90 days of the accident and be completed within 12 months of the accident. If the covered person is under 18, treatment must be completed before he or she reaches age 19.

The plan does not cover injuries due to biting or chewing. Coverage is based on the amount for the least expensive procedure that will provide a professionally adequate result.

Ambulance / medical transportation services

The plan covers charges for licensed ground ambulance services, to and from the nearest medical facility for immediate treatment.

It may also cover, if medically necessary, transportation by any form of licensed ambulance (including air ambulance), or by any vehicle normally used for public transportation for:

- transfer to the nearest medical facility or hospital for necessary treatment, and/or
- medical evacuation for admission to hospital in the province where the patient normally resides.

Your expenses are also covered for ground transportation to and from the hospital and airport at the points of departure and arrival.

Medical aids, services and supplies

On the written authorization of a physician, the EHC Plan will cover:

- artificial eyes or limbs (in the case of myoelectric or sport prostheses, consideration will be limited to the amount that would otherwise be paid for standard type artificial limbs);
- apnea monitor, aerochamber;
- breast prostheses, including up to six surgical bras per calendar year, when required as a result of a mastectomy;
- catheters, urinary kits;
- corrective lenses and frames (once only) following cataract surgery or if you lack an organic lens;
- custom-built orthopedic boots or shoes, or the actual cost of modifications and adjustments to stock item footwear;
- elastic support stockings (up to two pairs per calendar year);
- diagnostic procedures, radiology, blood transfusions and oxygen, including the equipment necessary for administering oxygen;
- hearing aids, up to $600 per person every 48 consecutive calendar months;
- standard insulin pumps and glucometers;
  (Note: deluxe insulin pumps and continuous glucose monitoring systems and supplies are only eligible if it is determined that this is the most appropriate means of treatment. To be considered for these expenses, the insurer requires the results of the patient's last three A1C (hemoglobin) levels prior to the initiation of the insulin pump, plus a copy of the patient's blood sugar diary times for the previous three months.)
- ostomy supplies, where a surgical stoma exists;
- purchase of custom-molded orthotics, up to $225 per pair and two pairs per person per calendar year;
- purchase of trusses, braces, splints, casts, cervical collars, crutches, canes, standard-type walker;
- rental, or at Sun Life Financial's option, purchase of a manual wheelchair, manual hospital bed or respirator/ventilator. Electric hospital beds, wheelchairs and scooters are excluded unless medically required and recommended in writing by the attending physician;
- repairs to a hospital bed, wheelchair and scooter, when required as a result of normal wear and tear;
- repairs to prosthetic appliances, when required as a result of normal wear and tear;
- stump socks (up to six pairs per calendar year);
- surgical bandages or dressings;
- synvisc and other viscosupplementation products for individuals who medically cannot tolerate other forms of therapies covered by this plan;
- tracheotomy supplies; and
- wigs, only after radiation or chemotherapy treatment, once per lifetime.

Professional services

The following professional services are covered, depending on the option that is selected:

- services of a physician, provided it is outside your province of residence, but within Canada (where this coverage is permitted by law);
- private-duty nursing services that are deemed to be within the practice of nursing and that are provided in the patient's home, by a registered nurse or a registered nursing assistant (or equivalent designation) who has completed an approved medications training program. Sun Life Financial suggests that a detailed treatment plan be submitted with cost estimates before nursing services begin so that it may advise you of any benefit that will be provided (note: under Option 3, private-duty nursing is not covered, and under Option 2 is limited to $10,000 per person per year).

  Charges for the following nursing services are not eligible:
  - services provided for custodial care, homemaking duties or supervision;
  - services performed by a nursing practitioner who is an immediate family member, or lives with the patient;
  - services performed while the patient is confined in a hospital, nursing home or similar situation;
  - services that can be performed by a person of lesser qualification, a relative, friend or member of the patient's household.

- paramedical services, provided by licensed, certified or registered paramedical practitioners when operating within their recognized fields, up to the limits set out in the table below:

Paramedical maximums *	Option 1 – Base Option	Option 2 – Buy Different	Option 3 – Buy Down	Option 4 – Buy Up
	Up to a maximum per person per calendar year	Up to a combined calendar year maximum of $1,000 per person	Up to a maximum per person per calendar year	Up to a combined calendar year maximum of $1,500 per person
Physiotherapist / Athletic therapist	$1,000	✓	$200	✓
Massage therapist	$400	✓	$200	✓
Psychologist	$35 for the initial visit and $20 per hour for each subsequent visit to a max of $1,000	✓	$200	✓
Speech therapist	$30 per hour to a max of $500	✓	$200	✓
Chiropractor	$400	✓	$200	✓
Osteopath or Chiropodist	$100 plus $25 for related x-rays	✓	$200	✓
Podiatrist	$100 plus $25 for related x-rays	✓	$200	✓
Naturopath	$200	✓	$200	✓
Nutritionist / Dietitian	Not applicable	✓	Not applicable	✓
Acupuncturist	Not applicable	✓	Not applicable	✓

* Unless indicated otherwise, the plan reimburses 100% of eligible expenses up to the specified maximums.

You do not, however, need to be referred for treatment by a physician. Only those expenses not covered by the provincial health plan in your province of residence (or beyond the provincial plan's annual maximum) will be reimbursed.

Vision care

You and your dependents will be covered for routine eye examinations, including refraction, once every two consecutive years.

Expenses for you and your dependents are eligible when recommended by a physician, ophthalmologist or an optometrist, subject to the limits set out in the table below. These include the purchase and fitting of prescription glasses, including prescription sunglasses (but excluding safety glasses and non-prescription sunglasses), or elective contact lenses, as well as repairs, or elective laser vision correction procedures.

Expense maximum	Option 1 – Base Option	Option 2 – Buy Different	Option 3 – Buy Down	Option 4 – Buy Up
Per person, every 24 consecutive months	$500	$400	$250	$500

What's *not* covered

Regardless of the option you select, the *myBenefits* Extended Health Care Plan does not pay any benefit or accept liability for claims relating to:

- services or supplies received outside of Canada (except those payable under Travel Plan coverage);
- expenses for services covered under the provincial health plan in your province of residence; expenses for these services can be claimed only after your provincial plan has paid out the annual maximum benefit allowed under that plan;
- charges for any illness or injury for which compensation is provided under a Workers' Compensation Act or similar legislation;
- charges above what is considered reasonable and customary;
- cosmetic surgery or treatment (when so classified by Sun Life Financial), unless as a result of accidental injuries and commenced within 90 days of an accident;
- examinations required for use by a third party;
- expenses that you are not legally obligated to pay;
- experimental treatment;
- travel for health reasons;
- any illness or injury that is the result of:
  - a self-inflicted bodily injury or sickness;
  - insurrection or war, declared or not (the restriction for injuries resulting directly from war or insurrection will be waived if you are temporarily outside of Canada on Candu business); or
  - participation in any riot, civil commotion or any other act of aggression;
- any charges for services, treatment or supplies that are performed or provided by an immediate family member or a person who lives with the patient;
- drugs, sera, injectables and supplies that are not approved by Health and Welfare Canada (Food and Drugs) or are experimental or limited in use, whether or not so approved;
- charges by a physician for travel time, cancelled appointments, advice given over the phone, completion of forms, or preparation of a letter; and
- charges for equipment considered by the administrator to be ineligible.

Under Option 2 – Buy Different, additional expenses can be claimed through your Health Care Spending Account (HCSA). *(See page 27 for details.)*

For details on how to file a claim under the Extended Health Care Plan, see page 44.

Travel Plan

Regardless of the *myBenefits* option you select, you will receive Travel Plan coverage for eligible out-of-province/country emergency medical expenses. This important and potentially valuable benefit provides additional financial protection if you suffer a health emergency during the first 60 days while you are travelling, vacationing or otherwise residing temporarily out of your home province or out of the country.

Your coverage (single or family) under this plan is automatically set based on the coverage you selected under the Extended Health Care (EHC) Plan. If you opt out of EHC (assuming you have comparable coverage elsewhere), you will automatically receive single coverage under the Travel Plan (unless you are already covered as a dependent by your spouse/partner who is also a Candu employee).

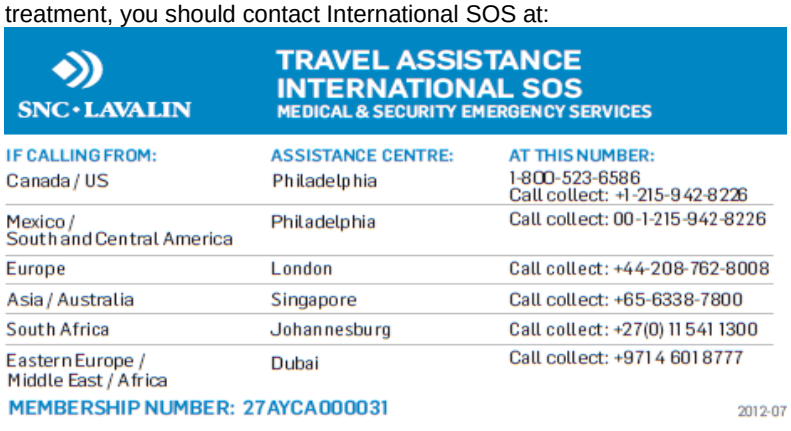
The premiums for Travel Plan coverage are fully paid for by Candu.

The Travel Plan covers reasonable and customary expenses for the treatment of an unexpected health emergency (provided those expenses are not covered by your provincial health plan). Coverage includes:

- In-patient hospital charges for the following:
  - the difference between the room and board benefit payable by the provincial health plan and the actual cost of ward accommodation; and
  - medically necessary hospital services and supplies furnished during hospital confinement.
- Hospital charges for medical and surgical treatment incurred on an out-patient basis.
- Physicians' charges for professional services.
- The expenses you incur outside of Canada (both emergency and non-emergency) will be considered for reimbursement in the same manner as those incurred in Canada for the following:
  - drugs;
  - health care facilities (semi-private room and board in excess of ward accommodation);
  - medical transportation services;
  - medical supplies and services;
  - dental services;
  - professional services (other than physician services); and
  - vision care.

Emergency Medical assistance while travelling

While you and your covered dependents are travelling for vacation or business, you are provided with emergency assistance through a worldwide communications network that operates 24 hours a day, seven days a week. The network locates medical services and obtains insurer approval for covered services. If while travelling you, your spouse/partner or dependent children experience an unexpected health emergency that requires immediate treatment, you should contact International SOS at:



SNC·LAVALIN

TRAVEL ASSISTANCE INTERNATIONAL SOS
MEDICAL & SECURITY EMERGENCY SERVICES

IF CALLING FROM:	ASSISTANCE CENTRE:	AT THIS NUMBER:
Canada / US	Philadelphia	1-800-523-6586 Call collect: +1-215-942-8226
Mexico / South and Central America	Philadelphia	Call collect: 00-1-215-942-8226
Europe	London	Call collect: +44-208-762-8008
Asia / Australia	Singapore	Call collect: +65-6338-7800
South Africa	Johannesburg	Call collect: +27(0) 11 541 1300
Eastern Europe / Middle East / Africa	Dubai	Call collect: +971 4 601 8777

MEMBERSHIP NUMBER: 27AYCA000031

2012-07

Health assistance services

The insurer provides a number of important health services:

A. **Medical referral** – to the nearest physician, dentist, pharmacist or appropriate medical facility, and verification of insurance coverage.

B. **Claims payment service** – if a hospital or other provider of medical services requires a deposit or payment in full for services, and the expenses exceed CDN$200. Payment and coordination of expenses will take into account the patient's provincial health plan coverage as well as this plan. Where payments exceed the benefits the patient is entitled to, Sun Life shall have the right to recover the excess amounts.

C. **Medical care monitoring** – by medical staff who will maintain contact, as frequently as necessary, with the covered person, the attending physician, and the covered person's personal physician and family.

D. **Medical transportation** – if medically necessary, arrangements will be made to transfer a covered person to and from the nearest medical facility or to a medical facility in the covered person's normal province of residence.

E. **Return of dependent children** – if left unattended due to the hospitalization of a covered person, arrangements will be made to return the children to their home. The extra costs over and above any allowance available under pre-paid travel arrangements will be paid. If necessary for a qualified escort to accompany the dependent children, expenses incurred for round-trip transportation will be paid.

F. **Trip interruption or delay** – if due to an illness or injury of a covered person, one-way economy transportation will be arranged to enable each covered person and a travelling companion (if applicable) to rejoin the trip or return home. Expenses incurred, over and above any allowance available under pre-paid travel arrangements will be paid.

   Travelling companion means one person travelling with the covered person whose fare for transportation and accommodation was prepaid at the same time as the covered person's fare.

   If the covered person chooses to rejoin the trip, further expenses incurred, which are related directly or indirectly to the same illness or injury, will not be paid.

G. **After hospital convalescence** – if a covered person is unable to travel due to medical reasons following discharge from a hospital, expenses incurred for meals and accommodation after the originally scheduled departure date will be paid, subject to the maximum for "Meals and Accommodation" noted below.

H. **Visit of a family member** – Expenses for round-trip economy transportation will be paid for an immediate family member to visit a covered person who, while travelling alone, becomes hospitalized and is expected to be hospitalized for longer than seven days. The visit must be approved in advance by Sun Life Financial.

I. **Vehicle return** – if a covered person is unable to operate his or her owned or rented vehicle due to illness, injury or death, expenses incurred for a commercial agency to return the vehicle to the covered person's home or nearest appropriate rental agency will be paid, up to a maximum of CDN$1,000.

J. **Identification of deceased** – if a covered person dies while travelling alone, expenses incurred for round-trip economy transportation will be paid for an immediate family member to travel, if necessary, to identify the deceased prior to release of the body.

K. **Meals and accommodation** – under the circumstances described in parts E, F, G, H and I of Health assistance services, expenses for meals and accommodation will be paid, subject to a combined maximum of CDN$2,000 per medical emergency.

Non-medical assistance services

The Travel Plan also covers a number of non-medical services:

A. **Return of deceased** – in the event of the death of a covered person, the necessary authorizations will be obtained and arrangements made for the return of the deceased to his or her home province. Expenses for the preparation and transportation of the body will be paid, up to a maximum of CDN$5,000. Expenses related to the burial, such as a casket or urn, will not be paid.

B. **Lost document and ticket replacement** – assistance in contacting local authorities is provided to help a covered person in replacing lost or stolen passports, visas, tickets or other travel documents.

C. **Legal referral** – to a local legal advisor and, if necessary, arrangement for cash advances from the covered person's credit cards, family or friends is provided.

D. **Interpretation service** – telephone interpretation service in most major languages is provided.

E. **Message service** – telephone message service is provided for messages to or from family, friends or business associates. Messages will be held for up to 15 days.

F. **Pre-trip assistance** – up-to-date information will be provided on passport and visa, vaccination and inoculation requirements for the country where the covered person plans to travel.

Exceptions

Sun Life Financial, and the company contracted by Sun Life to provide the travel assistance services described here, will not be responsible for the availability, quality, or results of any medical treatment, or the failure of a covered person to obtain medical treatment or emergency assistance services for any reason.

Emergency assistance services may not be available in all countries due to conditions such as war, political unrest or other circumstances that interfere with the provision of any services.

What's *not* covered

The following expenses will not be covered:

- treatment for a medical condition:
  - that is not considered a medical emergency;
  - for which you have been receiving ongoing medical attention that, prior to your trip, was identified as requiring immediate care, or recurs after you have been advised to return home or move to a different health facility;
- charges for treatment if you are medically able to return home or transfer to a health facility that is part of ManuAssist's medical network;
- any illness or injury that is the result of:
  - a self-inflicted bodily injury or sickness;
  - insurrection or war, declared or not (the restriction for injuries resulting directly from war or insurrection will be waived if you are temporarily outside of Canada on Candu business); or
  - participation in any riot, civil commotion or any other act of aggression;
- travel to obtain medical treatment, except as allowed under referral coverage;
- examinations required for the use of a third party;
- travel for health reasons;
- cosmetic surgery or treatment (when so classified by Sun Life Financial), unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident;
- any charges for services, treatment or supplies that are performed or provided by an immediate family member or a person who lives with the patient; and
- drugs, sera, injectables and supplies that are not approved by Health and Welfare Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.

For details on how to file a claim under the Travel Plan, see page 44.

Dental Plan

We all need dental care. The type and amount of coverage you'll need can vary dramatically depending on your teeth, dental history, and, of course, the dependents you are covering. That's why your *myBenefits* Dental Plan gives you a wide range of dental options – all of them designed to keep you and your family smiling.

Your options

Under the *myBenefits* program, you have four options to consider, as summarized in the table on page 13. The option you choose will determine your dental coverage.

You may choose between single or family coverage. Keep in mind that under all plan options and levels of coverage, the Dental Plan will reimburse reasonable and customary charges up to the amounts specified in the current fee schedule for general practitioners of your dentist's province.

If a reimbursement amount is not shown in the applicable fee schedule, the insurer will determine a reasonable and customary amount.

Remember, if you elect Option 2 – Buy Different, you can always use the money in your Health Care Spending Account to offset the cost of those services and procedures that are not covered (or fully covered) under the Dental Plan – as long as the expense qualifies as an eligible deduction under the *Income Tax Act.* Please see the *Health Care Spending Account* section beginning on page 27 for details.

Eligible expenses

While we've tried to list most of the eligible services, the list is too extensive to complete here. Please contact Sun Life Financial at 1-866-881-0583 should you have a question about a specific procedure not listed here.

Basic services

The Dental Plan covers the following basic dental services:

- complete oral examination once every three years;
- one recall oral exam per person, including teeth cleaning, every nine months (every six months for children under 18 years of age);
- one periodontal examination (one per person every six months);
- one specific oral examination (one per person every six months);
- one emergency oral examination (one per person every six months);
- fluoride treatments (one per person every nine months; every six months for children under 18);
- one unit of scaling (one unit) and one unit of polishing per person every nine months (every six months for children under 18 years of age);
- bite wing x-rays (once per person every nine months; six months for children under 18) and full-mouth x-rays (once per person every 36 months);
- fillings (amalgam, acrylic or composite);
- extractions;
- pain control;

- pit and fissure sealants (permanent molars only, one replacement per tooth per lifetime);
- repair, relining or rebasing of dentures (by a licensed denturist, denture therapist, technician or mechanic);
- tests and laboratory examinations;
- required consultations;
- oral surgery, including removal of impacted wisdom teeth;
- space maintainers and retainers for missing primary teeth;
- stainless steel and preformed crowns;
- excision of a tumour or cyst;
- treatment of periodontal and other diseases of the gums or tissues of the mouth; and
- endodontic treatment, including root canal therapy.

Major restorative

The Dental Plan covers the following major dental restoration services:

- extensive restorations, including:
  - bridge repair;
  - gold foil restorations;
  - metal inlay restorations;
  - porcelain inlay or onlay;
  - retentive pins in inlays and crowns;
  - post and core;
  - porcelain repair;
  - other restorative services;
- replacement of temporary dental solutions with permanent dental solutions within 12 months;
- first installation, including adjustments, of a partial or full denture once every five years;
- removable dentures once every five years;
- replacement of a denture that is at least five years old and no longer serviceable;
- adjustments of inlays, onlays and crowns;
- replacement of inlays, onlays and crowns that are at least five years old and no longer serviceable;
- repair or recementing of bridgework;
- the first installation of bridgework;
- replacement of bridgework that is at least five years old and no longer serviceable; and
- cosmetic treatment within 90 days of an accident.

Orthodontia
(not available under Option 3 – Buy Down)

Reimbursement (up to the rate per person specified under each option) for orthodontic treatment and eligible orthodontic appliances – that is, appliances required to straighten permanent teeth, regain lost space, maintain space, correct cross-bites and/or control oral habits.

Both adults and children are eligible for treatment, subject to the applicable lifetime maximums.

Alternate treatment

Where the person chooses a course of treatment that is not covered under the Dental Plan, reimbursement will be limited to the least expensive course of treatment that is covered by the plan and that would produce professionally adequate results for a given condition. Sun Life Financial will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Treatment plan

If a course of treatment under the Dental Plan is expected to cost more than $500, you should ask your dentist to submit a treatment plan to the insurer, Sun Life, before treatment begins. A treatment plan is simply a description of the proposed procedure and its related cost. The insurer will review the plan and report what portion of the cost (if any) is covered under the Dental Plan. This will allow you to determine how much reimbursement you can expect – before your treatment begins. Eligible expenses will be reimbursed as work is actually completed.

For details on how to file a claim under the Dental Plan, see page 44.

What's not covered

The *myBenefits* Dental Plan does not pay any dental benefit or accept liability for claims relating to expenses arising from:

- Injury resulting directly or indirectly from service in the armed forces of any country or participation in a riot. The restriction for injuries resulting directly from war or insurrection will be waived if you are temporarily outside of Canada on Candu business.
- Any injury or illness for which the person is entitled to benefits under any workers' compensation act.
- Examinations required for the use of a third party.
- Any charges for services, treatment or supplies that are performed or provided by an immediate family member or a person who lives with the patient.
- Dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union.
- The replacement of an existing dental appliance that has been lost, mislaid or stolen.
- The replacement of a temporary dental solution with a permanent dental solution unless the replacement has been completed within 12 months.
- Dental services and supplies rendered for full-mouth reconstruction, for a vertical dimension correction.
- Treatment that is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition.
- Implants, or any services rendered in conjunction with implants. However, if an implant is the treatment of choice and the implant is part of a bridge, crown or denture, then only the cost of the bridge, crown or denture will be considered eligible.
- Cosmetic surgery or treatment (when so classified by Sun Life Financial), unless required as a result of accidental injuries and commenced within 90 days of an accident.

Health Care Plans

Effective date of coverage

Your coverage under the *myBenefits* program becomes effective on the date you are eligible.

You must be actively at work for insurance to become effective (except dental). If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are actively at work again. This restriction will be waived if you are applying for coverage to become effective on the date your coverage ceases under a spouse's/partner's plan.

Your dependent's insurance becomes effective on the date the dependent becomes eligible.

Continuing coverage under the EHC, Travel and Dental Plans

Your coverage under the *myBenefits* EHC, Travel and Dental Plans can continue while you are receiving benefits under a leave of absence, such as a disability leave, a maternity or parental leave, a compassionate leave, or other type of leave of absence. In some cases, depending on the reason for the leave of absence, you may be required to pay the full premium cost.

You can change the "class" of your coverage (single versus family) under the EHC, Travel and Dental Plans if you have a qualifying life event that alters the makeup of your family (i.e., a marriage, divorce, the qualifying or disqualifying of a spouse/partner, or the birth/adoption of a child). For example, you could switch from **family to single** coverage within 31 days of the date of a divorce.

When coverage ends under the EHC, Travel and Dental Plans

Under the *myBenefits* program, coverage under the EHC, Travel and Dental Plans (including coverage of your dependents) will cease on the first day of the month following the date you cease to be an eligible employee.

If you retire on the last day of the month, EHC and Travel coverage for you and your dependents will end on the last day of the following month.

If you were to die on the last day of the month, your EHC, Travel and Dental coverage for your dependents will end on the last day of the month following the month of your death.

If your employment with Candu ends, claims for expenses incurred **before** your employment ended must be submitted within 90 days of your coverage termination date to be eligible for reimbursement.

Health Care Spending Account

Under the *myBenefits* program, Option 2 – Buy Different, offers you and your family important and affordable financial protection against regular medical and dental expenses. As comprehensive as the option is, it doesn't cover everything. That's where the Health Care Spending Account (HCSA) comes in. This important plan feature lets you use **company-funded** pre-tax dollars to pay for a host of eligible medical and dental expenses not covered specifically under the *myBenefits* Option 2 Extended Health Care and Dental Plan benefits.

How it works

If you choose coverage under Option 2 – Buy Different, the company will make an automatic contribution to a separate Health Care Spending Account (HCSA) opened on your behalf. Effective each January 1st the company will make an HCSA contribution equal to:

- $200 if you have elected EHC single coverage (coverage for you alone);
- $400 if you have elected EHC family coverage.

Contribution amounts will be pro-rated in year one if you join the *myBenefits* program – and select coverage under Option 2 – mid-way (from July 1) through the year.

You simply use the money in your HCSA to pay for any eligible medical, drug or dental expenses that are not covered (or fully covered) by your *myBenefits* program.

For example

Say you choose Option 2 – Buy Different, but you expect to incur about $300 in health expenses that are not covered. Perhaps you want to buy disposable contact lenses that cost $700. All you have to do is:

1. purchase your contact lenses;
2. claim the first $400 through the Extended Health Care Plan; and
3. submit the remaining $300 through your HCSA.

Assuming you chose family coverage, you will be reimbursed for the full cost of your contact lenses; you will also have $100 remaining in your HCSA to cover additional health and/or dental expenses. Without the HCSA, you would have to pay the extra $300 out of your own pocket – using after-tax dollars.

Eligible expenses

Your HCSA covers all eligible expenses as defined in the *Income Tax Act*, but only to the extent that those expenses are not covered under a provincial or private health plan.

There are literally hundreds of eligible expenses that are covered – everything from prescription eye glasses to teeth bleaching. For a complete list of covered expenses, visit the Canada Revenue Agency website at www.cra-arc.gc.ca and search for bulletin it519r2.

To qualify as an eligible expense, the service, procedure or item must be provided or prescribed by a medical, dental or paramedical practitioner who is licensed according to the laws of the province in which he or she is practicing. Eligible expenses exclude private health plan premiums.

The taxing truth

The HCSA can help you reduce your tax hit. This is because you do not pay income tax on the money allocated to your HCSA by Candu. And that makes a huge difference in how much money you have available to spend on medical, prescription drug and dental-related expenses.

Consider the numbers. Let's say you live in Ontario, have family coverage under Option 2, and you earn about $50,000. The $400 allocated to your HCSA can be spent entirely on health care expenses, with no taxes to pay on that money. If you simply added the $400 to your gross income, you would pay taxes on that money somewhere between $84 and $124, depending on your tax rate. That will leave you with approximately $276 to $316 after tax. Stated another way, the spending power of $400 in your HCSA could be equal to as much as $524 in gross additional earnings.

In other words, if you use the HCSA, you win in two ways:

- First, you get to use money allocated to your account by the company; it's not necessarily money you pay out of your own pocket.
- Second, you get to spend this money on a pre-tax basis, which can dramatically increase your purchasing power.

If you live in Quebec …

any medical, prescription drug and dental expenses (including related retail sales tax and administration fees) paid with money from your HCSA will be considered a taxable benefit. You'll escape the federal tax hit, but provincial income tax will apply.

Use it or lose it

For the HCSA to qualify as a tax-preferred program, the Canada Revenue Agency (CRA) says there must be an element of risk. In the case of your HCSA, the risk is what we call the "use-it-or-lose-it" factor.

Basically, you must spend the money allocated to your HCSA within one benefit plan year. If you don't spend the money, you lose it. In other words, any money allocated to your HCSA effective January 1st must be spent by December 31st of the same year. Any money remaining after this benefit plan year will be forfeited under CRA rules.

Carrying forward expenses

There is a flip side to the use-it-or-lose-it provision. You can carry forward eligible health and dental expenses incurred in one benefit plan year and submit them for reimbursement under your HCSA in the following benefit plan year. But they can only be rolled over once. These expenses must be paid in full by the following March 31st – otherwise they will no longer be eligible for payment from your HCSA.

Claims for expenses must be submitted within:

- 60 days from the end of the benefit plan year in which the expense was incurred, for an expense that is to be paid from your dollar allotment for that plan year; or
- 60 days from the end of the benefit plan year following the plan year in which the expense was incurred, for an expense that is carried forward to be paid from your dollar allotment for that following plan year.

For details on how to file a claim under your Health Care Spending Account, see page 45.

If you leave

If your employment with Candu ends, you will no longer have access to funds in your HCSA. Claims for expenses incurred **before** your employment ended must be submitted within 60 days of your EHC coverage termination date to be eligible for reimbursement.

Long Term Disability

Long Term Disability (LTD) provides a continuing source of income during disabilities that extend beyond 182 days (26 weeks) of benefits payable under the Short Term Sick Leave and Intermediate Sick Leave Plans.

You will be eligible to receive LTD benefits once you have satisfied the "qualifying period." This qualifying period is the greater of:

- 182 days, or
- the number of days for the complete payout of disability benefits from the Short Term Sick Leave and Intermediate Sick Leave Plans, or
- 182 days of benefits payable under a workers' compensation plan.

Your LTD benefits are also subject to approval by the insurer.

Your benefit

The LTD Plan will provide a continuing source of income during an approved disability leave. If your disability extends beyond the qualifying period, and you are approved for benefits, you will receive a minimum regular benefit equal to:

- 66⅔% of your monthly earnings at the end of the qualifying period to a maximum monthly benefit of $28,000 with evidence of insurability (EOI), or $24,000 without EOI.

Tax considerations

Because Candu pays for a portion of your LTD premiums, any benefit payments you receive from the plan will be taxed as income. This is a Canada Revenue Agency rule.

Cost-of-living adjustment (COLA)

While receiving LTD benefits, your benefit amount may be adjusted on January 1st each year to reflect increases in the cost of living based on the Consumer Price Index (CPI), up to a maximum of 4%. The first cost of living adjustment will be pro-rated on a monthly basis to reflect the number of complete calendar months that you received payments in the preceding year. Should the CPI decrease, your monthly benefit will remain at its existing level.

Pension/benefit deduction

Your LTD benefit will be subject to a pension/benefit deduction as determined by you and Candu.

Defining disability

You will be considered totally disabled if you are unable to perform, due to an illness or injury, the duties of:

- **your own occupation** during the qualifying period and the following two years (24 months) from the start of your disability;
- **any occupation** for which you are qualified, or may reasonably become qualified by training, education or experience *after* you have been receiving LTD benefits for two full years (24 consecutive months).

The start date of your disability is the date you are first absent from work.

Whether or not a suitable position is available will not be considered when assessing your disability. You do not typically need to be confined to a treatment centre during your disability leave. However, you must be under the regular care of a physician from the start date of your disability. You must also be prepared to participate in a rehabilitation program – or to pursue rehabilitative employment – considered appropriate by the insurer (see *Rehabilitation program* on the next page).

Integration of benefits

Any LTD benefit payments you receive will be reduced immediately by:

- Workers' Compensation, WSIB , or similar coverage;
- Canada or Quebec Pension Plans (CPP/QPP), excluding dependent benefits; and
- any periodic payments you receive (or are entitled to apply for and receive) under the Public Service Superannuation Act (PSSA) Plan.

The benefit amount payable will be further reduced so that your total income from *all sources* does not exceed 85% of your pre-disability earnings. Total income from all sources includes those stated above and any benefits you are entitled to receive from:

- disability benefits payable under a public pension plan (CPP/QPP);
- periodic payments that you receive or are entitled to apply for and receive under the PSSA;
- benefits payable under any workers' compensation act;
- earnings or payments from any employer, not including termination compensation payments or earned leave payments;
- disability benefits payable under any other group, association or franchise insurance plan;
- disability benefits payable under any other government plan, excluding Employment Insurance benefits
- retirement or pension benefits provided by an employer and/or government;
- income replacement indemnity payable under any automobile insurance plan or policy; and/or
- earnings recovered through a legally enforceable cause of action against some other person or corporation in accordance with provisions under third-party liability.

If you receive LTD benefit payments in excess of what should have been paid, the insurer reserves the right to recoup the excess from you, or to deduct it from future LTD benefit payments.

When determining the amount of such income, the following will apply:

- Benefits from all sources which began before commencement of your current disability will not be taken into account;
- If you do not apply for a benefit for which you are eligible, the amount of such a benefit will be estimated by Sun Life Financial and assumed to be paid;
- Any amount which is not payable on a monthly basis will be converted to a monthly basis;
- Disability benefits payable under a pension plan will not be taken into account until actual determination of an award is made, provided an agreement to reimburse Sun Life Financial is signed by you and furnished at the time of the claim. Otherwise, any government award which has not been determined by the time this benefit is payable will be estimated and deducted from the monthly benefit. Adjustment to correct such payments under this policy will be made after the award has been determined.
- For disability payments under a public pension plan, the only changes which are taken into account are those resulting from:
  - A change in the benefit formula of 10% or more,
  - A change in dependent status, or
  - An error in determining the benefit amount.
- Any change due to a cost of living adjustment will not be taken into account; and
- Benefit payments from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Sun Life Financial.

Rehabilitation program

In the event you are determined to be Totally Disabled, the LTD Plan's rehabilitation program may, if appropriate, help you get back to a productive lifestyle. Participation in a rehabilitation program must be offered and approved by the insurer.

If you participate in a rehabilitation program, your benefit payment will be offset by 50% of your rehab earnings during the first 24 months of benefit payments, and your total income from all sources may not exceed 100% of your adjusted pre-disability benefit earnings. After you have been receiving LTD benefits for two full years (24 consecutive months), your LTD benefit payments will cease when your rehabilitation earnings reach 66⅔% of the current monthly earnings for your normal occupation.

Recurrent disability

If you resume working your regular hours after a period of disability, but become disabled again within six months due to the same or a related cause, the later disability will be considered a continuation of the previous disability. Your LTD benefits will, subject to approval, resume immediately – and you do not need to satisfy another qualifying period.

If the recurrence occurs more than six months following your return to work, it will be treated as a new disability. In this case, you must satisfy the 26-week qualifying period again before LTD benefits resume, and you must also be re-approved for benefits.

What the plan does not cover

LTD benefits are not payable for any of the following:

- Any period during which you are:
  - not under the continuous active care and treatment of a qualified physician,
  - collecting Employment Insurance or maternity benefits.
- Any disability that is the result of:
  - self-inflicted injuries or illness;
  - insurrection or war, declared or not (the restriction for injuries resulting directly from war or insurrection will be waived if you are temporarily outside of Canada on Candu business);
  - active service in the armed forces;
  - participation in any riot, civil commotion or any other act of aggression;
  - any occupation for compensation or profit, other than a rehabilitation program;
  - your refusal to participate in a rehabilitation program;
  - alcoholism, drug addiction, or the use of any hallucinogen, unless you are participating in a therapeutic program recognized by Sun Life Financial and are under the continuous care of a medical specialist in this field; and
  - committing a criminal offence, direct or indirect.

For newly hired employees, the plan does not cover any disability that commences within the first 12 months that a person is insured if the disability is related to a condition for which the person, within three consecutive months immediately prior to becoming insured, was treated, tested, took medication, visited or consulted a physician.

Maternity leaves

LTD benefits are not payable while you are on maternity leave. However, if you were receiving LTD benefits immediately prior to the start of your maternity leave, benefits will resume immediately following your leave – provided you are still disabled. Similarly, complications arising directly from your pregnancy are covered.

Continuing coverage

While you are on LTD:

- your *myBenefits* coverage under the core and optional plans will continue, provided you continue to pay your share of the premium costs; and
- if approved by the insurer, your premium payments may be waived for Basic Life, and Optional Group Life and Accident Insurance for you and your spouse/partner. Premiums for LTD are automatically waived while you are receiving LTD benefits.

While receiving LTD benefits, you can only make a change in your benefit options and/or coverage (single or family) during the re-enrollment period every other year, or if you have a qualifying life event that affects the makeup of your family (e.g., a marriage, divorce, birth, etc.) that in turn requires you to adjust your coverage under the *myBenefits* program.

When benefit payments stop

An LTD benefit period will end, and benefit payments will stop, on the earliest of the following events:

- The date you are no longer totally disabled.
- The date you reach age 65. However, should you complete the qualifying period after your 64th birthday but prior to your 65th birthday, the monthly income payments will continue beyond age 65 as long as you are totally disabled, subject to a maximum of 12 monthly payments.
- The date you fail to undergo, when requested by Sun Life Financial, medical, psychiatric or psychological, educational and/or vocational examinations by examiners selected by Sun Life Financial.
- The date you fail to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program for alcoholism, drug addiction or substance abuse treatment program when recommended by Sun Life Financial.
- The date you refuse to complete and return a Reimbursement Agreement/Direction form or comply with the terms of a signed Reimbursement Agreement/Direction form, when requested, in accordance with the provisions under a third-party liability.
- The date you die.

If you terminate your employment with Candu while you are on disability leave, you will continue to receive disability benefits – provided you became disabled while you were still insured under the *myBenefits* LTD Plan. Please note, however, that the insurer reserves the right to request proof of your continued disability from time to time.

Waiving LTD coverage

If you have 25 years of pensionable service, you have the option to waive LTD coverage. Coverage will cease three months following the date of your request, provided that you do not revoke your request within the three-month period.

When coverage ends

Under the *myBenefits* program, your LTD coverage will end when you end your employment with Candu, reach age 65 (less the qualifying period), retire, or die – whichever comes first.

Basic Life and Supplementary Life Insurance

Life insurance is an important source of financial protection for your loved ones in the event that you die. Given the importance of this coverage, the *myBenefits* program offers you a basic company-paid benefit and a supplementary benefit subsidized, in most cases, by Candu. The Basic Life and Supplementary Life Insurance Plans are provided through Sun Life Financial.

Basic Life Insurance

As a member of the *myBenefits* program, you automatically receive basic company-paid life insurance equal to:

- One times your annual earnings (rounded to the next multiple of $250 if not already a multiple).

Candu pays the full premium cost of your Basic Life coverage.

Supplementary Life Insurance

You also automatically receive Supplementary Life Insurance equal to:

- An additional one times your annual earnings (rounded to the next multiple of $250 if not already a multiple).

If you select Options 1, 2 or 4, coverage is mandatory. Candu pays 1/6th of the cost of your Supplementary Life premium, while you pay the remaining 5/6^{ths} of the premium cost.

However, participation in Supplementary Life is optional if you select Option 3 – Buy Down, of the *myBenefits* program. If you do choose to purchase Supplementary Life coverage under Option 3, your coverage will not be subsidized and you will pay the full premium cost.

If you select Option 3, you can choose to waive Supplementary Life coverage. However, take note that if you waive coverage, and during a future re-enrollment choose an option where Supplementary Life is mandatory, or you choose the optional Supplementary Life coverage under Option 3, you will be required to provide evidence of insurability and your coverage will be subject to the insurer's approval.

Regardless of the option you select, the actual cost of this Supplementary coverage will depend on your annual earnings (i.e., the amount of coverage).

Your core Life Insurance benefits

Coverage	1. Base Option	2. Buy Different	3. Buy Down	4. Buy Up
Basic Life Insurance				
Benefit	1 times annual earnings	1 times annual earnings	1 times annual earnings	1 times annual earnings
Premium sharing	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0	▪ Candu pays 100% ▪ You pay 0
Supplementary Life Insurance				
Benefit	1 times annual earnings	1 times annual earnings	▪ **Coverage optional** ▪ 1 times annual earnings	1 times annual earnings
Premium sharing	▪ Candu pays 1/6th ▪ You pay 5/6^{ths}	▪ Candu pays 1/6th ▪ You pay 5/6^{ths}	▪ **You pay 100%**	▪ Candu pays 1/6th ▪ You pay 5/6^{ths}

Waiver of premium
(Basic Life Insurance)

If you become totally disabled, you may become eligible for the waiver of your Basic Life Insurance premiums under two different provisions: Provision A if you have coverage under the LTD Plan, or Provision B if you have waived LTD coverage. (Waiving LTD coverage requires that you have at least 25 years of pensionable service.)

Provision A *(you have LTD coverage)*
If you are covered under the LTD Plan and become totally disabled, you will be entitled to a waiver of Basic Life Insurance premiums, provided Sun Life Financial receives proof of acceptance for benefit payments under the plan.

However, premiums will not be waived if disability is related to any condition that commenced prior to the date you became covered under the LTD Plan, and for which you received treatment within the three consecutive months immediately preceding the date coverage began. This qualifying period for waiver of premiums applies only until you have been covered under the LTD Plan for 12 consecutive months.

Your premiums will be waived until:

- you are no longer disabled;
- you reach age 65;
- Sun Life Financial requests, but does not receive, further proof of total disability;
- you refuse or fail to undergo, when requested by Sun Life Financial, medical, psychiatric or psychological, educational and/or vocational examinations and evaluations by examiners selected by Sun Life Financial;
- you refuse or fail to undergo medical, psychiatric or psychological treatment, or participate in a rehabilitation program for alcoholism, drug addiction or substance abuse treatment program when recommended by Sun Life Financial; or
- you die.

While premiums are being waived, your Life Insurance benefit is subject to all policy provisions, except those regarding policy termination.

Provision B *(you have waived LTD coverage)*
If you are not a member of the LTD Plan, and become totally disabled, you will be entitled to:

- waiver of the premium payable for your Basic Life benefits, or
- payment to you of your Basic Life benefit amount in monthly installments.

Your eligibility for this waiver of premiums or monthly payments will be based on the following conditions:

- total disability commences while you are covered under the Basic Life Plan and before you reach age 65;
- total disability exists for at least 182 days;
- Sun Life Financial receives proof of this disability within 12 months of the date total disability commenced; and
- for the monthly installment option, you must be totally and permanently disabled and you must have waived coverage under the LTD Plan after having completed a minimum of 25 years of pensionable service.

Premiums will not be waived and no benefit is payable if disability is related to any condition that commences prior to the date you become covered under the Basic Life Plan, and for which you have received treatment within the three consecutive months immediately preceding the date coverage began. This limitation applies only if you have less than 12 consecutive months of service.

Monthly installments

Sun Life Financial will pay you the amount of insurance in force on the date you became totally and permanently disabled, in 60 monthly installments, plus any additional payments as may be determined by Sun Life Financial.

The first installment is paid on the first of the month following the date on which you become entitled to waiver of the premium. Subsequent installments are paid on the first of each month after that. The last monthly installment is paid on the first of the month in which the earliest of the following events occurs:

- you reach age 65; or
- you are paid the 60th installment.

Death benefits

If you die while you are totally disabled, your unpaid monthly installments will be paid as a lump sum to your beneficiary, provided:

- death occurs:
  - while your premiums are being waived; or
  - within the 31-day conversion option period; or
  - after the 31-day conversion option period, but within three months following the 182-day qualifying period for total disability; and
- proof of death is submitted within 12 months from the date of death; and
- proof of total disability, if not already submitted, is submitted within 12 months from the date of death, and establishes that total disability commenced while you were covered under the Extended Health Care Plan and before you reached age 65.

If death occurs after the 31 days following termination of coverage but within three months following the qualifying period of total disability, and you have applied for, and received, an individual policy through the conversion option, the individual policy (free of any claim), must be surrendered to Sun Life Financial before a benefit is paid. If the individual policy is surrendered, Sun Life Financial will refund the premiums paid for such a policy to your estate.

Conversion option

(Basic Life and Supplementary Life Insurance)

If your *myBenefits* coverage is terminated or reduced, you may be eligible to convert your Basic Life and Supplementary Life Insurance coverage to an individual policy without medical evidence. You must apply for the individual policy and pay the first monthly premium within 31 days of the termination of your Basic Life and Supplementary Life Insurance. If you die during this 31-day period, the amount of your Basic Life and Supplementary Life Insurance available for conversion will be paid to your beneficiary or estate, even if you don't apply for conversion.

For more information about this conversion option, please contact Human Resources.

Optional Group Life Insurance & Accident Insurance Plan

You have the option to purchase additional Life Insurance coverage beyond your Basic and Supplementary Life coverage, or you can purchase life insurance for your spouse/partner, under the Optional Group Life Insurance Plan, subject to the approval of the insurer. You can also purchase accidental death and dismemberment insurance for you and/or your spouse/partner under the Accident Insurance Plan. The Optional Group Life Insurance and Accident Insurance Plan is provided through Sun Life Financial.

Optional Group Life is available in units of $10,000 up to a maximum of $250,000 for you and/or your spouse/partner. If you also choose to purchase Accident Insurance, your coverage will be based on your Optional Group Life coverage. You cannot purchase Accident Insurance without first purchasing Optional Group Life.

Your Optional Group Life Insurance and Accident Insurance benefits are summarized in the following table:

Optional Group Life Insurance & Accident Insurance	
Optional benefit	**Coverage**
Employee	▪ Units of $10,000 to a maximum of $250,000 ▪ Can select Optional Group Life only or Optional Group Life *with* Accident Insurance ▪ If Accident Insurance is selected, coverage amount is equal to the Optional Group Life Insurance
Spouse/partner	▪ Units of $10,000 to a maximum of $250,000 ▪ Can select Optional Group Life only or Optional Group Life *with* Accident Insurance ▪ If Accident Insurance is selected, coverage amount is equal to the Optional Group Life Insurance

Premiums

How much you pay for your Optional Group Life Insurance and Accident Insurance will vary depending on your age, gender, smoker status and the amount of coverage you select. When it comes to paying for your optional coverage, your premiums will be paid through the convenience of payroll deductions.

Smoker/non-smoker rates

Smokers typically pay more for their coverage than non-smokers. This reflects the fact that medical research indicates that, on average, non-smokers live longer than smokers.

Under the terms of the *myBenefits* program, a non-smoker is anyone who has not used tobacco-related products (including patches, nicotine chewing gum, etc.) for a full 12 months. A non-smoker cannot use tobacco-related products during the benefit period or coverage will become void.

If you (or your spouse/partner) indicate that you are a non-smoker and then start using tobacco-related products, you must notify the administrator immediately and switch to smoker rates – otherwise your Optional Life Insurance coverage will become void.

You can change your smoker/non-smoker status by notifying Human Resources.

Evidence of insurability

When you first enroll, or apply to increase your Optional Group Life Insurance, evidence of insurability (EOI) will be required. (*See page 8 for more information on EOI.*)

Effective date

Any coverage for which EOI is required will not go into effect until the date the EOI is approved by the insurer.

If you are not actively at work when your coverage would otherwise take effect, your coverage will take effect upon your return to work.

Waiver of premium

If you become totally disabled continuously for between six and 12 months while insured for this benefit, your premiums for Optional Group Life Insurance and Accident Insurance will be waived if approved.

You will be considered totally disabled if you are unable to perform the duties of any occupation for which you are reasonably qualified by education, training or experience.

Living death benefit

If you are diagnosed with a terminal illness and have a life expectancy of 12 months or less, you can collect a portion of your life insurance benefit. This benefit, payable while you are still alive, will equal 50% of your Optional Group Life Insurance, to a maximum of $100,000. You must complete the living benefit loan form and be approved.

Similarly, if you choose Optional Group Life Insurance for your spouse/partner and he or she is diagnosed as terminally ill with a life expectancy of 12 months or less, you can collect a portion of the insured amount. The living benefit payable will equal 50% of the insured amount, to a maximum of $100,000. You must complete the living benefit loan form and be approved.

What's not covered under Optional Group Life

No benefit is payable for any amount of Optional Group Life Insurance that has been in force for less than two years if death is due to suicide, while sane or insane.

Continuing coverage

You can continue your Optional Group Life Insurance and Accident Insurance coverage while receiving Short Term Sick Leave, Intermediate Sick Leave and Long Term Disability (LTD) benefits based on the following:

- you must continue to pay your premiums while receiving sick leave benefits; and
- premiums will be waived while you are on LTD, subject to the approval of the insurer.

You cannot change your coverage amounts while on Short Term Sick Leave, Intermediate Sick Leave or LTD.

When coverage ends

Optional Group Life Insurance and Accident Insurance will end when you request your coverage to end, you or your spouse/partner reach age 65, you or your spouse/partner no longer qualify *(see **Eligibility** on page 6)*, or you or your spouse/partner die… whichever comes first.

Conversion option

When your coverage ends, you may convert your Optional Group Life Insurance to an individual policy (to a maximum of $200,000) within 31 days. You and/or your spouse/partner will not have to provide evidence of insurability (EOI) if the application is submitted and the first premium payment is made before the end of the 31-day conversion period. If you or your spouse/partner die during the conversion period, you will automatically receive the benefit selected under the Optional Group Life Plan, even if an application for a conversion of coverage has not been made.

Accident Insurance benefit amounts

The actual benefit amount payable under the Optional Accident Insurance Plan will depend on the nature and extent of the injury, as summarized in the table below:

Covered loss	% of principal sum
Loss of life	100%
Hemiplegia (complete and irrevocable paralysis of both upper and lower limbs on one side of the body)	200%
Paraplegia (complete and irrevocable paralysis of both lower limbs, bowel and bladder due to injury of the spinal cord)	200%
Quadriplegia (complete and irrevocable paralysis of both upper and lower limbs)	200%
Loss of both hands, both feet, or sight of both eyes	100%

Covered loss	% of principal sum
Loss of one hand and one foot	100%
Loss of one hand and entire loss of sight of one eye	100%
Loss of one foot and entire sight of one eye	100%
Loss of speech and hearing	100%
Loss of use of both hands or both feet	100%
Loss of use of one hand and one foot	100%
Loss of one arm or one leg	75%
Loss of use of one arm or one leg	75%
Loss of one hand, one foot or sight of one eye	67%
Loss of use of one hand or one foot	67%
Loss of speech or hearing	50%
Loss of hearing in one ear	50%
Loss of thumb and index finger on same hand	33%
Loss of four fingers of one hand	33%
Loss of all toes of one foot	25%

No more than 100% will be paid for all losses due to any one accidental injury – except in the case of hemiplegia, paraplegia, or quadriplegia where the total amount paid will not exceed 200%. For example, if you permanently lost the use of an arm due to an injury, you would receive 75% of the principal sum from the Accident Insurance Plan. However, if in the same accident you also lost one leg, your total benefit would be limited to 100%.

Permanent and total disability

If, as a direct result of an accidental injury while insured under this benefit, a person becomes permanently and totally disabled, Sun Life will pay the permanent and total disability benefit shown in the benefit schedule, provided:

- the person becomes permanently and totally disabled within 365 days after the date of the accidental injury, and
- the person has been permanently and totally disabled for a continuous period of 12 months and remains so at the end of this period.

The benefit is payable to the person in a lump sum.

Additional Accident Insurance coverage

In addition to the coverage outlined above, the Accident Insurance Plan provides you and your covered family members with a range of additional benefits. These valuable benefits are summarized below:

Repatriation benefit

If you (or a covered family member) die as the result of an accident that occurs more than 150 kilometres from home, the plan will cover the costs related to preparing and shipping the body to your city of residence. The maximum benefit payable is $10,000.

Rehabilitation benefit

If you are injured in an accident, the plan will cover reasonable and necessary costs associated with retraining you for an occupation that you would otherwise not have pursued. Expenses must be incurred within three years of the accident. The maximum benefit payable is $10,000. The plan does not cover room, board, ordinary living, travel, or clothing expenses.

Spousal occupational training benefit

If you die in an accident, and your spouse/partner must participate in a formal occupational training program, the Accident Insurance Plan will cover reasonable and necessary training costs. The training program must be to help your spouse/partner qualify for employment in an occupation for which he or she would otherwise not have sufficient qualifications. Expenses must be incurred within two years of the accident. The maximum benefit payable is $10,000. The plan does not cover room, board, ordinary living, travel, or clothing expenses.

Education benefit

If you die as a direct result of a covered accident, the Accident Insurance Plan will provide a special education benefit on behalf of your dependent children. The education benefit will be equal to the actual tuition expenses incurred, to a maximum of the lesser of 5% of the principal sum, or $5,000 per year, for the continuing education of any dependent child who, at the date of the accident:

- is enrolled as a full-time student in a school for higher learning above the secondary school level, or
- is attending secondary school and subsequently enrolls as a full-time student in a school for higher learning within 365 days after the date of your death.

The special education benefit is payable annually for up to four consecutive years, but only if the dependent child continues his or her education as a full-time student in a school for higher learning.

What's *not* covered under Accident Insurance

The Accident Insurance Plan will not cover any losses incurred under the following conditions:

- an intentionally self-inflicted bodily injury, sickness or death;
- committing or attempting to commit an unlawful act;
- insurrection or war, declared or not, (the restriction for injuries resulting directly from war or insurrection will be waived if you are temporarily outside of Canada on Candu business);
- participation in any riot, civil commotion or any other act of aggression;
- flying in, boarding, leaving, or descending from any aircraft that is owned operated or leased by or on behalf of Candu;
- riding in, boarding or leaving, or descending from any aircraft as a pilot, operator or member of the crew;
- an infection (except from an accidental cut or wound), illness or disease from the medical treatment of any illness or disease; or
- injuries sustained while operating a motor vehicle and under the influence of any intoxicant or with a blood-alcohol level exceeding 80 milligrams of alcohol per 100 millilitres of blood at the time of the injury.

Critical Illness Insurance

The *myBenefits* program provides an Optional Critical Illness Insurance Plan that helps guard against the financial consequences of a serious, life-threatening or life-altering illness. The purpose of the benefit is to help you deal with any loss of income, medical costs, home modifications, or career changes stemming from your illness.

It will provide a one-time, lump-sum benefit in the event that you (or your covered spouse/partner) are diagnosed with one of a specified list of 22 common critical conditions, including:

- Aortic surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign brain tumour
- Blindness
- Cancer (Life-threatening)
- Coma
- Coronary artery bypass surgery
- Deafness
- Dementia, including Alzheimer's disease
- Heart attack
- Heart-valve replacement or repair
- 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

Your options

You can elect to purchase Critical Illness Insurance for yourself and your spouse/partner. The payment of premiums is made from payroll deductions.

Optional benefit	Coverage
Employee	▪ Units of $10,000 to a maximum of $150,000 ▪ Benefit is tax fee and payable to you (employee)
Spouse/partner	▪ Units of $10,000 to a maximum of $150,000 ▪ Benefit is tax fee and payable to you (employee)

Evidence of insurability

Evidence of insurability (EOI) is required for all new and increased Employee and Spouse/Partner coverage in excess of $20,000. Coverage will be effective from the first of the month coincident with or next following the date the EOI is approved by the insurer, not the date of election.

Benefit payments

Under current legislation, benefit amounts will be paid as a tax-free lump sum if the covered individual is still living 30 days after the date of diagnosis or surgery (if applicable). The payment will always be paid to the employee, even if the payment relates to coverage for a spouse/partner.

What is covered

For full details on coverage please consult the Sun Life Critical Illness Brochure at: https://www.sunlife.ca/ca/Insurance/Health+insurance/Critical+illness+insurance/Sun+Critical+Illness+Insurance/25+1+full-payout+illnesses?vgnLocale=en_CA

Or **Sunlife.ca > Insurance > Health Insurance > Criticall Illness Insurance > Sun Critical Illness Insurance > 25 +1 full payout illnesses**. Here you can click on the drop down for each illness to obtain the details as they pertain to each specific illness.

Submitting a claim

You and your beneficiaries should follow the procedures outlined below when making a claim.

Extended Health Care claims

You can print out a personalized claim form from by logging in to Sun Life at sunlife.ca.

The claim form will include mailing instructions. Be sure your claim form includes your contract number (150301) and your employee number, and save a copy for your own records.

If you provided banking information, your reimbursements will be deposited directly into your bank account. At the same time, Sun Life will send you an explanation of benefits (EOB) that you can use for the co-ordination of benefits.

Claims must be submitted by the end of the calendar year following the year in which the expense was incurred. If you end your employment with Candu, you must claim all outstanding expenses within 90 days of the date coverage ends.

Sun Life Benefit Card – prescription drugs

A pay-direct drug (PDD) card is available to be printed online for prescription drug coverage under the Extended Health Care Plan.

A PDD card enables your pharmacist to verify your coverage and process drug claims on the spot. The pharmacist will bill the plan directly for all eligible expenses. You pay only the portion of your drug bill that isn't covered.

Keep in mind that not all drug expenses can be processed with your PDD card. If you need to submit a paper-based claim, you will need to include the contract number (150301).

Claims must be submitted by the end of the calendar year following the year in which the expense was incurred. If you end your employment with Candu, you must claim all outstanding expenses within 90 days of the date coverage ends.

Dental Plan claims

Claims can be submitted either electronically or using paper-based forms.

If your dentist has electronic access to the Sun Life claims system, he or she can submit a claim on your behalf. You will need to tell your dentist the plan contract number (150301). Be sure to ask your dentist for a receipt for your records.

If you wish to submit a paper-based form, you can print out a personalized claim form from Sun Life's website at sulife.ca.

Sun Life will permit reimbursement directly to your dentist. Otherwise reimbursements will be deposited in your bank account or a cheque will be mailed to you, depending on your preference. You, in turn, must pay the dentist.

Sun Life will send you an explanation of benefits (EOB) that you can use for the coordination of claims.

Claims must be submitted by the end of the calendar year following the year in which the expense was incurred. If you end your employment with Candu, you must claim all outstanding expenses within 90 days of the date your coverage ends.

Health Care Spending Account claims

You can print out a personalized Extended Health Care claim form from Sun Life at: www.sunlife.ca. If you have coverage under other benefit plans, you must submit claims to those plans first. The remaining portion can be claimed under the Health Care Spending Account.

Claims for expenses must be submitted within:

- 60 days from the end of the plan year in which the expense was incurred, for an expense that is to be paid from your dollar allotment for that plan year; or
- 60 days from the end of the plan year following the plan year in which the expense was incurred, for an expense that is carried forward to be paid from your dollar allotment for that following plan year.

Your claim form will include mailing instructions. Be sure your claim form includes your contract number (150301) and your employee number, and save a copy for your own records. **Ensure that you check the box on the claim form authorizing Sun Life to reimburse your expense with funds from your HCSA.**

Reimbursements will be deposited in your bank account or a cheque will be mailed to you, depending on your preference.

Following payment of a claim, Sun Life will send you an explanation of benefits (EOB). The EOB will report the balance remaining in your HCSA. The EOB is also accessible online at www.sunlife.ca.

If your employment with Candu terminates, claims for expenses incurred **before** your employment ended must be submitted within 60 days of your termination date to be eligible for reimbursement.

LTD claims

Should you be rendered totally disabled your claim will transition from Short Term Disability to Long Term Disability and any forms required will be sent to you directly by Sun Life.

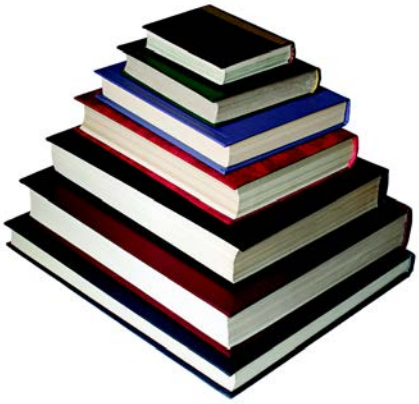
Optional Group Life and Accident Insurance claims

In the event of a claim under the Group Life Insurance or Accident Insurance Plans, a written claim should be filed as soon as possible, but no later than six years following the date of death (life coverage), or three months following the date of a loss or injury (accident coverage), for which a claim is being made. Claim instructions should be requested by you or your beneficiary by contacting your Human Resources department.

Critical Illness claims

In the event of a claim under the Critical Illness Insurance Plan please contact Sun Life at 1-866-881-0583 no later than 30 days after the diagnosis of the illness for which a claim is being made.

Glossary of terms



Beneficiary: The individual(s) you name to receive payment from your Basic Life, Supplementary Life, or Optional Group Life Insurance and Accident Insurance benefit if you die. If you do not name a beneficiary, benefits will be paid to your estate.

Benefit period: The 24-month benefit period under the *myBenefits* program runs from January 1st of one year to December 31st of the following year (e.g., January 1, 2014 to December 31, 2015).

Coordination of benefits (COB): If you are covered under the *myBenefits* program and another group plan, the payment of eligible expenses can be shared by both plans. There are, however, standard industry procedures for submitting claims under more than one plan. For details, refer to page 9.

Dependent child: A natural or adopted child, step-child or foster child of you and/or your spouse/partner who is unmarried, and is:

- under age 21; or if a full-time student, is:
  - under age 26 for Quebec residents; or
  - under age 25 for residents of other provinces;
- not employed on a full-time basis; and
- not eligible for coverage as an employee under this or any other group benefits program; or
- any age, with pre-approval of the plan administrator, if the child is incapacitated on the date he or she reaches the age when coverage would normally terminate and was covered under this benefits program immediately prior to that date. A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on you for support, maintenance and care, due to a mental or physical disability.

Earnings: Your gross earnings, excluding bonus, commissions and overtime, but including premium allowances as defined by Candu.

Eligible dependent: Your spouse/partner and/or dependent children.

Eligible employee: Means you are an active employee of Candu, and are either:

- a continuous full-time employee who works 37.5 hours per week; or
- a regular part-time employee who works a minimum of 15 hours per week;

and,

- a resident of Canada; or
- a resident of Canada who is temporarily assigned outside Canada, and full contributions are being made on your behalf to keep your government pension plan and/or government health insurance plan (or equivalent plan) in force.

Health Care Spending Account (HCSA): An account containing monies that can be used on a tax-preferred basis to pay for eligible medical, prescription drug and dental expenses. Eligible expenses are as defined by the Canada Revenue Agency. Eligible expenses in an HCSA can be carried forward for one benefit period (12-month carry forward of expenses). Any monies allotted to an HCSA but not used within 12 months are forfeited.

Non-smoker: If you have not used any tobacco-related products (i.e., cigarettes, cigars, patches, chewing tobacco, and nicotine gum) in the last 12 months, you can consider yourself a non-smoker.

Qualifying life event: This is an event that requires you to change your chosen benefit coverage status under the Health and Dental Plans (e.g., single to family or vice versa.).

Qualifying life events include:

- a marriage, separation or divorce;

- the birth or adoption of a child;
- the death of a spouse/partner or child;
- a child over 21 returning to school full-time (you can increase from single to family coverage only);
- dependent children no longer qualifying for coverage (you can decrease from family to single coverage only); and
- the loss of group benefits coverage under your spouse's/partner's plan (e.g., due to a change in your spouse's/partner's employment).

If you wish to change your benefits coverage, you must do so **within 31 days of your qualifying life event**. You can change your coverage by contacting Human Resources.

If you miss this 31-day window, your current selections will remain in effect for the remainder of the two-year benefit period. Remember, you will be given an opportunity to update your benefit selections during the next re-enrollment period.

Qualified physician: Refers to a medical doctor who is licensed to practice medicine where the services are provided.

Smoker: Anyone who has used **any** tobacco-related products (i.e., cigarettes, cigars, patches, chewing tobacco, nicotine gum) within the last 12 months.

Spouse/partner: The person of the same or opposite sex who is either:

- legally married to you through an ecclesiastical or civil ceremony, or
- has been continuously cohabitating with you in a conjugal relationship for at least one year and which you publicly represent as your spouse/partner. The term conjugal relationship includes conjugal relationships between partners of the same sex.

For more information

For more information about your *myBenefits* program, go to:

- the *myBenefits* web page on the Candu intranet, or
- Sun Life Financial at 1-866-881-0583 www.sunlife.ca

Privacy

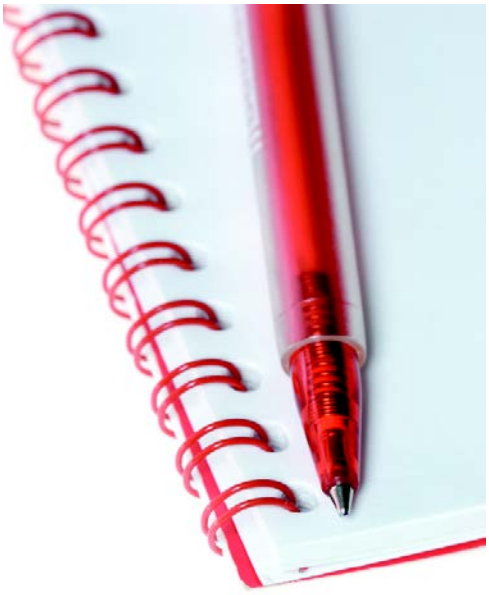
Protecting your privacy

Protecting your privacy is a priority for Candu, and an important part of the *myBenefits* program. Our insurers and administrators maintain confidential files containing personal information about you and your *myBenefits* program contracts. This information is used to administer the *myBenefits* program, make payroll deductions, pay benefits, and help you make informed benefit choices.

The individual benefit plan carriers have established – and will continue to maintain – appropriate safeguards to protect the confidentiality of your personal information in accordance with privacy guidelines (available upon request) and applicable laws.

Access to your confidential files is restricted to those employees and representatives who are responsible for administering and servicing the *myBenefits* program, or any other person who you have authorized. You have a right to view the information in your file and, where appropriate, provide a written request to correct any inaccuracies.

The final word



This booklet is intended to provide a reasonable and easy-to-understand summary of your *myBenefits* program. In no way does it confer any contractual rights or obligations.

The full provisions of the individual plans are contained in the official plan contracts, available from Human Resources. If there are any discrepancies between the official contracts and this booklet, the terms of the contracts will apply in all cases.

Coverage under the various plan options is limited to a 24-month benefit period running from January1 of year one, to December 31 of year two. Any changes in the terms and conditions of the individual plans will be communicated during the bi-annual re-enrollment period and will take effect for the next benefit period.

Your Health Care Spending Account benefits are provided directly by Candu. Sun Life Financial has been contracted to adjudicate and administer your claims for these benefits following standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and the *myBenefits* program.

Candu reserves the right to change, amend or terminate its benefits program as conditions warrant in the future. In addition, the company reserves the right to amend the terms and conditions of coverage, as well as the amount charged to individual plan members, based on the financial performance of the individual plans that make up your *myBenefits* program.