Amendment Agreement No. 31

Rectification to Group Policy 87065

Issued To

Wabush Mines, Cliffs Mining Co., Managing Agent

This amendment is effective January 1, 2015.

Please file the attached replacing pages in the "Contract-Current" section.

Please file the History Summary and your copy of this agreement with the replaced pages in the "Contract-History" section.

Signed at our Head Office, Toronto, Ontario.

Chief Executive Officer

Secretary

Clarica Life Insurance Company and Sun Life Assurance Company of Canada were amalgamated into one company on December 31, 2002 with the name Sun Life Assurance Company of Canada. All references to Clarica Life Insurance Company or Clarica in this document should be read to mean Sun Life Assurance Company of Canada (*Sun Life).*

Table of Contents

Overview – Policy #87065 – Wabush Mines, Cliffs Mining Co., Managing Agent

Scully Mine Union Employees

Division	Class	
1	1	Scully Mine active union employees
15	15	Scully Mine retirees of pre-March 1999 who were under 62 at retirement and surviving spouse of retirees (drug plan only)
16	16	Scully Mine retirees on or after March 1, 1999 but prior to October 12, 2004
17	17	Scully Mine retirees of pre-March 1999 who were age 62 or over at retirement and surviving spouse of active employees who died prior to October 12, 2004
18	18	Scully Mine employees who became disabled prior to March 1, 1999
20	20	Scully Mine employees who became disabled on or after October 12, 2004 and who are entitled to Long Term Disability benefits
	20A	Scully Mines employees who became disabled on or after October 12, 2004 and who are not entitled to Long Term Disability benefits
30	30	Scully Mine employees who retired on or after October 12**,** 2004 and surviving spouse of active employees who died on or after October 12, 2004
115	115	Scully Mine surviving spouse of employees who retired after October 12, 2004 (drug plan only)

Pointe-Noire Union Employees

Division	Class	
2	2A	Pointe-Noire active union employees
4	4	Pointe-Noire active union employees 65 years of age or more
5	5	Pointe-Noire retirees of pre-March 1999 who were under age 62 at retirement who are currently age 65 and over and surviving spouse of retirees age 65 and over at the time of death (drug plan only)
6	6	Pointe-Noire retirees currently age 65 or over who retired before March 1999 and who were age 62 or over at retirement
25	25	Pointe-Noire retirees of pre-March 1999 who were under age 62 and currently under age 65 and surviving spouse of retirees under age 65 at the time of death (drug plan only)
26	26	Pointe-Noire retirees on or after March 1, 1999 but prior to October 12, 2004 and surviving spouse of active employees who died prior to October 12, 2004

27	27	Pointe-Noire employees who became disabled on or after October 12, 2004 and who are entitled to Long Term Disability benefits
	27A	Pointe-Noire employees who became disabled on or after October 12, 2004 and who are not eligible or entitled to Long Term Disability benefits
40	40	Pointe-Noire employees who retired on or after October 12, 2004
105	105	Pointe-Noire – Drugs only – Sun Life second payer
125	125	Pointe-Noire – Drugs only – Sun Life first payer

Agreement

Policyholder	Wabush Mines, Cliffs Mining Co., Managing Agent
Group Policy Number	87065
Effective Date	September 1, 2003

We, Sun Life Assurance Company of Canada, agree with you, Wabush Mines, Cliffs Mining Co., Managing Agent, to insure certain persons according to the provisions of this policy. Premiums (as determined in the policy) are payable by you at our Head Office.

The policy and the application form the entire contract of insurance between Sun Life Assurance Company of Canada and Wabush Mines, Cliffs Mining Co., Managing Agent.

Signed at our Head Office, Toronto, Ontario.

Chief Executive Officer

Secretary

Definitions

Actively working and active work	mean the performance for you of all of the regular duties of the person's own occupation for one full working day or shift.
Calendar year	means January 1 to December 31.
Dependant	means a member's spouse or a dependent child of a member or his spouse.
Dependent child	means a natural, adopted, or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on the member for maintenance and support and is permanently residing in the member's household and who is 1. under 19 years of age, 2. under 26 years of age and attending a college or university full-time, or 3. physically or mentally incapable of self-support and became incapable to that extent prior to reaching 19 years of age.
Evidence of insurability	means written proof that a person meets our medical underwriting requirements.
Family unit	means a member and his insured dependants.
He, his and him	refer to both genders.
Insured dependant	means a dependant for whom the member is insured. If we do not approve evidence of insurability required for a dependant, he will not be an insured dependant.
Member	means a person who is insured, but does not include a dependant.
Month	means the period of time from a date in one calendar month to the same date in the following calendar month.
Period of grace	for the payment of premiums, is 31 days.
Physician	means a doctor of medicine (M.D.) legally licensed to practice medicine.
Policy anniversary	means January 1, 2014 and an anniversary of that date.
Policy year	means the period between the effective date and the first policy anniversary or a period of 12 months beginning on a policy anniversary.
Premium due date	means the 1st day of each month.
Rate of earned income	on a given date, means the rate of the regular standard monthly wage received by the member according to the hourly wage rate for the highest job class in which the employee worked for a period of at least 6 months during the two years preceding his disability unless he was voluntarily reduced, in which case, the standard hourly wage rate of his regular job at the time of the disability, times 2,080 hours, divided by 12.

Spouse means

1. the person who is married to the member or under any other formal union recognized by law, or
2. a person of the opposite or same sex who has been publicly represented for not less than 3 years as the member's spouse, or
3. a person of the opposite or same sex who has been publicly represented for 1 year as the member's spouse if a child is born from the union. For Quebec residents, there is no minimum cohabitation period if a child is born from the union.

If the spouse is not married to the member, the spouse shall cease to be considered as such after a period of 3 months during which said spouse failed to cohabit with the member.

We, us and our refer to the Sun Life Assurance Company of Canada.

Work Stoppage includes, but is not limited to, strikes, layoffs, maternity/paternity/parental/ educational leaves, lock-outs and sabbaticals.

You and your refer to the Policyholder.

Policy

The Contract

This policy may not be amended nor provisions waived without written notification by our officials authorized to sign policies.

This policy is not eligible to participate in any surplus earnings distributed by us.

The currency of this policy is Canadian.

No rights or interests of a member may be assigned.

Your statements in the application, other than fraudulent statements, are incontestable after this policy has been in force continuously for 2 years.

Administration

You are responsible for the administration of the policy according to the instructions we provide.

If earnings are required to calculate benefit amounts, you are responsible for reporting changes in earnings when they occur.

We may inspect your payroll records and other records relevant to this policy at any time to verify amounts of insurance, the premiums charged and other matters relating to this policy.

Premiums

The first premium is due on the effective date. After that, premiums are due monthly in advance.

The amount of the premium payable on a premium due date is determined by applying the monthly premium rates in force to the total units of insurance in force on that premium due date.

The initial monthly premium rates are in force on the effective date. We may change premium rates on the effective date of an amendment or on a premium due date. We will give you 150 days written notice of a premium rate change unless it is due to an amendment. The premium rates will not change before the first policy anniversary because of experience-rating.

Period of Grace

The policy continues in force during the period of grace. Premiums must be paid for a period during which the policy remains in force, including the period of grace. The period of grace is allowed for the payment of each premium except the first.

Termination of Policy

This policy or any billing division terminates when a premium has not been paid before the end of the period of grace.

This policy terminates automatically upon your receivership or bankruptcy.

You may terminate this policy by giving us written notice. The date of termination is the date we receive the notice or the termination date specified in the notice, if later. If the date of termination is not a premium due date, a partial premium is payable for the period from the last premium due date to the date of termination.

We may terminate this policy on the first policy anniversary or on a premium due date after that by giving you 60 days written notice.

The insurance of all members stops on the termination date of this policy and claims incurred after that are not eligible for payment.

Eligibility

Eligibility to be a Member

A person is eligible, and continues to be eligible, to be a member while he meets all of the following conditions:

1. He is actively working.
2. He regularly works for you at least 35 hours each week.
3. He has continuously been employed by you at least as long as the waiting period.
4. He is a resident of Canada.

An employee cannot be both insured as a member and a dependant under any Wabush plans.

A retired employee is eligible, and continues to be eligible, to be a member while he meets all of the following conditions:

1. He is a member immediately before his date of retirement.
2. He is a resident of Canada.

Participation is compulsory.

An employee who is classified as an independent, owner-operator, consultant, contract employee or is self-employed will not be eligible to be a member.

Waiting Period

- Long Term Disability – on the day immediately following completion of 2 years of continuous service
- All Other Benefits – on the first of the month following completion of the probationary period under the collective bargaining agreement

Eligibility for Dependant Insurance

A person is eligible, and continues to be eligible, for dependant insurance while he meets all of the following conditions:

1. He is a member.
2. He has at least one dependant.
3. His dependants are residents of Canada.

Participation is compulsory.

A dependant cannot be a dependant of more than one member under any Wabush plans.

Commencement and Termination of Insurance

Enrolment for Insurance

An eligible person enrols by submitting a completed enrolment form. A member requests all other dependant insurance by submitting a completed enrolment form.

If an eligible person enrols for Optional Life Insurance more than 31 days after the date he became eligible, he must submit a completed enrolment form and evidence of insurability to us. If he requests Optional Dependant Life Insurance more than 31 days after the date he became eligible for dependant insurance, he must submit a completed enrolment form and evidence of insurability for his spouse and dependent children to us.

Effective Date of Insurance of a Member

A person becomes a member for Optional Life Insurance on the later of the date that he becomes eligible or the date that we approve the evidence of insurability, unless he is not actively working on that day due to disease, injury or work stoppage.

A person becomes a member for all other insurance on the date he becomes eligible, unless he is not actively working on that day due to disease, injury or work stoppage.

If, due to disease, injury or work stoppage an eligible person is not actively working on the date the insurance would be effective, he becomes a member on the date he returns to active work. A member becomes insured for dependant insurance on the latest of

1. the date that he becomes eligible for dependant insurance,
2. the date that he requests dependant insurance, or
3. the date that we determine the insurability of all of his dependants, and approve at least one dependant,

unless he is not actively working on that day due to disease, injury or work stoppage.

Comparable Coverage

If an eligible person or a member is insured for comparable coverage, he may decline to be insured for the Extended Health Insurance Provision or the Dental Insurance Provision. If this comparable coverage stops, an eligible person or a member will be insured for the similar coverage provided by this policy.

If a dependant is insured for comparable coverage, a member may decline to be insured for dependant insurance for the Extended Health Insurance Provision or the Dental Insurance Provision. If this comparable coverage stops, a member may request the similar coverage provided by this policy.

The insurance that replaces the comparable coverage is effective on the date that the comparable coverage stops.

If a member requests this dependant insurance more than 31 days after the comparable coverage stops, he is considered a late entrant and he must submit evidence of insurability for each dependant to us. The insurance that replaces the comparable coverage is effective on the date we approve the evidence of insurability. If we don't approve evidence of insurability required, the insurance will not be effective.

Changes in Insurance

An increase in the provision benefits, the amount of insurance of a member or the amount of dependant insurance of a member due to a policy amendment or change in classification becomes effective on the date of the policy amendment or change in classification, unless the member is not actively working on that day.

If, due to disease, injury or work stoppage, a member is not actively working on the date an increase in the provision benefits, the amount of insurance of a member or the amount of dependant insurance of a member would be effective, the increase becomes effective on the date he returns to active work.

A decrease in the provision benefits, the amount of insurance of a member or the amount of dependant insurance of a member due to a policy amendment or change in classification, becomes effective on the date of the policy amendment or change in classification for all members and their dependants.

Termination of Insurance, Leave of absence, Lay-off or Discharge referred to arbitration

Termination of Insurance

Unless specified otherwise in this policy, the insurance of a member terminates on the date that he no longer meets all of the conditions for Eligibility to be a Member. The dependant insurance of a member terminates on the date he no longer meets all of the conditions for Eligibility for Dependant Insurance.

If a member, due to disease or injury, no longer meets all of the conditions, his insurance may be continued, subject to our approval, until the date of termination of his insurance that you specify.

Leave of absence

If a member is on a leave of absence, all coverage, except Short Term and Long Term Disability Insurances, will be continued up to a maximum period of 6 months from the end of the month in which he last worked. The Short Term and Long Term Disability Insurances will be terminated on the date the leave of absence begins.

With respect to Members of Local Union 6285 only, if while on a Company approved leave of absence for the purpose of attending a recognized Newfoundland training institute, all coverage except Short Term, Long Term Disability and Dental Insurances will be continued at no cost to the employee for the first 6 months of such absence. To continue benefits beyond the first 6 months due to such absence, a member must pay the full amount of such coverage directly to the Company. Such amounts are due monthly, prior to the first of the month for which such coverage is to be provided. Any failure by the member to make the required payments when due will be cause for cancellation of such coverage. Dental insurance will be continued for up to 4 weeks (28 days).

Lay-off

If a member becomes disabled due to a non-occupational accident or sickness that occurred while he was on lay-off, he will, upon presentation of completed claim forms and after exhaustion of EI sickness or injury benefits or other employment benefit, if applicable, be eligible for Short Term Disability Insurance coverage starting no sooner than the last day he was due to report to work, if he had accepted his recall, had he been able to do so, and providing the recall date is within a period of 6 months after the date of lay-off. In this situation, Short Term Disability Insurance must be continued and premiums need to be paid.

All coverage under the Plan will continue in effect to the end of the month following the month in which the member is laid-off, except for Dental insurance for which coverage will be continued until the end of the month in which the lay-off starts. The member may continue such coverage for an additional period of 6 months by paying the current premium cost in advance of such coverage.

Discharge referred to arbitration

In case of discharge, the Basic Life Insurance shall remain in force. Furthermore, an employee who so desires may keep in force his Optional Life Insurance by paying the required premium, in advance at the time of discharge.

These Life Insurance benefits shall remain in force for a period of 12 months or until the arbitration award is rendered, whichever comes first.

If a member fails to tell us every fact material to his insurance or misrepresents those facts, that insurance is voidable.

Statements made on a member's enrolment form or on an evidence of insurability form which are fraudulent or a misstatement of age may be contested at any time.

Other statements are incontestable 2 years after the statements are made.

Basic and Optional Member Life Insurance Provision

Amount of Benefit

The amount of benefit is equal to the maximum benefit.

Death Benefit - Claims

The member appoints the beneficiary when enrolling for insurance. The beneficiary designation may be changed, if permitted by law. The member must submit written notice of the change.

When a member dies, we will pay the beneficiary the amount of benefit in force on the date of death.

If no beneficiary has been appointed or if the beneficiary has predeceased the member, payment will be made to the member's estate.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If the member resides outside Québec and is designating a minor as the beneficiary, the member may wish to designate someone to receive the death benefits during the time the beneficiary is a minor. If the member resides outside Québec and has not designated a trustee, current legislation may require us to pay the death benefit to the court or to a guardian or public trustee. If the member resides in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor’s behalf. Alternatively, the member may wish to designate the estate as beneficiary and provide a trustee with directions in the member's will.

A claim must be received by us within 6 years of the date of death.

The claimant must submit proof of the claim and the right to receive the benefit to us. Proof of claim is at the claimant's expense. We may require other information we consider necessary for the assessment of a claim.

Benefits may be paid in cash or used to provide an income in the form of an annuity. The choice of settlement may be made by the member or by the beneficiary if the member did not make a choice.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or

2. regarding claims for which we have made some payment, more than one year after we have made the last payment with respect to the claim.

Death Benefit - Exclusions

No benefit is payable for any amount of Optional Life Insurance that has been in force for less than 2 years if death is due to suicide, while sane or insane.

Disability Benefit - Definitions - (Applicable to Optional Member Life Insurance)

If a member is insured under a group Long Term Disability Insurance Provision issued by us, “totally disabled”, “total disability” and “qualifying period” are determined under that provision.

If a member is not insured under a group Long Term Disability Insurance Provision issued by us

1. “totally disabled” and “total disability” mean that, during and after the qualifying period, the member has a medical impairment due to injury or disease which prevents him from performing, in any setting, the essential duties of any occupation for which he has at least the minimum qualifications.

   The medical impairment must be supported by objective medical evidence. The availability of work for the member does not affect the determination of totally disabled or total disability.

2. “qualifying period” means 6 months and begins on the date the member becomes totally disabled.

Disability Benefit - Claims - (Applicable to Optional Member Life Insurance)

If the member is insured under a group Long Term Disability Insurance Provision issued by us, he must submit a claim to us along with proof of claim under the group Long Term Disability Insurance Provision.

If the member is not insured under a group Long Term Disability Insurance Provision issued by us, he must submit a claim to us after he has been totally disabled continuously for 6 months but not beyond 12 months after the date he became totally disabled.

We may require

1. proof that the member continues to be totally disabled,
2. an examination by an independent physician or a registered psychologist appointed by us,
3. proof of the member's age,
4. a vocational or functional capacities assessment, and
5. other information we consider necessary for the assessment of a claim.

Proof of claim is at the claimant's expense.

From time to time we may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the claimant may not be entitled to some or all benefit payments.

There is a time limit for appealing our decision to decline or terminate a claim. An appeal must be made within 3 months of such a decision and must be accompanied by new objective medical evidence.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or
2. regarding claims for this Disability Benefit which are initially approved, more than one year after the date the member ceases to be insured or the member's premiums cease to be waived.

Disability Benefit - Continuation of Insurance - (Applicable to Optional Member Life Insurance)

If a member becomes totally disabled before he reaches 65 years of age, his life insurance continues provided we receive proof that he has been totally disabled from the same or related causes for the qualifying period. The amount of insurance continued will be the amount in force on the date he became totally disabled. We will waive premiums for the continued insurance following the qualifying period.

If a member dies before he submits proof to us that he is totally disabled, his insurance is considered to be in force, provided

1. he is under 65 years of age at his death,
2. death occurs within 12 months of the date he became totally disabled, and
3. we receive proof that he was totally disabled continuously from the date he became totally disabled to the date of death.

The Disability Benefit terminates on the earlier of the date that

1. the member is no longer totally disabled,
2. the member fails to submit proof to us that he continues to be totally disabled,
3. the member fails to submit to an examination at our request, by an independent physician or a registered psychologist we appoint, or
4. the member reaches age 65.

When the Disability Benefit terminates, the member's Life Insurance terminates. When he returns to active work, that insurance will be reinstated upon request.

Disability Benefit - Consecutive Periods of Total Disability (Applicable to Optional Member Life Insurance)

If a member stops being totally disabled while satisfying a qualifying period and, within 30 days, he becomes totally disabled again from the same or related causes, that total disability is considered to be a continuation of the previous total disability.

If a member stops being totally disabled following a total disability for which premiums are waived and, within 6 months, becomes totally disabled again from the same or related causes, that total disability is considered to be a continuation of the previous total disability.

The amount of insurance continued for consecutive periods of total disability is determined from the Member Life Insurance Provision in force on the date the previous total disability began.

Conversion Privilege - Policy Available

If the member's insurance terminates for any reason other than at his request, he may convert it to an individual policy on his life without submitting evidence of insurability.

The application and premium must be received by us within 31 days after termination of insurance. The premium for the individual policy will be determined by the current scale of premiums for the class of risk to which the applicant belongs.

The individual policy may be a term insurance policy for a period of one year, a term insurance policy to the age of 65 years or a permanent insurance policy under a regular plan being issued by us. The term insurance policies are not available to a person who has reached the age of 65 years.

The individual policy will be in exchange for all benefits terminated under this provision. It will contain the same provisions as are regularly included by us in new individual policies but will exclude disability insurance and accidental death insurance.

Conversion Privilege - Amount and Effective Date

The amount of the individual policy will not exceed the lesser of

1. the amount of the insurance terminated,
2. the maximum amount of insurance for which the person has been insured under this provision less the total amount of individual insurance still in force on the person's life which was previously obtained through the Conversion Privilege of this provision, or
3. $200,000, or the amount stipulated in any applicable legislation, if greater.

The individual policy will be effective 31 days after the insurance is terminated.

The amount of the individual policy will not exceed the amount of the insurance terminated less the amount of insurance in force under a new group policy that replaces this policy.

Conversion Privilege - Right to Disability Benefit

When proof is submitted to us that the group insurance replaced by the individual policy would have been in force under the Disability Benefit, the rights to that insurance will be restored if all of the following conditions are met

1. the proof is received by us within 12 months of the individual policy's effective date,
2. the individual policy is surrendered without claim except for the return of premiums paid on the individual policy, and
3. the insurance under that individual policy is void.

Conversion Privilege - Continuation of Benefit After Termination

If the member's insurance terminates while this provision continues in force and the member dies within 31 days after termination of insurance, we will pay the beneficiary the amount of insurance which the member could have converted to an individual policy on his life through the Conversion Privilege of this provision, or the amount stipulated in any applicable legislation, if greater.

Optional Dependant Life Insurance Provision

Claims

A claim must be received by us within 6 years of the date of death.

The claimant must submit proof of the claim and the right to receive the benefit to us. Proof of claim is at the claimant's expense. We may require other information we consider necessary for the assessment of a claim.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or
2. regarding claims for which we have made some payment, more than one year after we have made the last payment with respect to the claim, or
3. regarding claims for the Disability Benefit which are initially approved, more than one year after the date the dependant ceases to be insured or the dependant’s premiums cease to be waived.

Payment of Benefit - Optional Dependant Life Insurance

When an insured dependant dies, we will pay the member the amount of benefit in force on the date of death.

Death Benefit - Exclusions

No benefit is payable for any amount of Optional Dependant Life Insurance that has been in force for less than 2 years if death is due to suicide, while sane or insane.

Conversion Privilege - Spouse

If the dependant insurance for the spouse terminates due to the termination of the member's insurance, the spouse may convert the amount of the dependant insurance terminated to an individual policy on his life without submitting evidence of insurability.

The conditions that apply to the Conversion Privilege for the member's insurance will apply to the Conversion Privilege for the dependant insurance.

Conversion Privilege - Child

Where necessary in order to comply with applicable legislation: If the dependant insurance for a child terminates due to the termination of the member's insurance, the member may convert the amount of the dependant insurance terminated to an individual policy on the child’s life without submitting evidence of insurability.

The conditions that apply to the Conversion Privilege for the member's insurance will apply to the Conversion Privilege for the dependant insurance.

Continuation of Benefit After Termination –Dependent

If the dependant insurance terminates and the dependant dies within 31 days after termination of insurance, we will pay the member the amount of insurance which could have been converted to an individual policy on the dependant life's through the Conversion Privilege of this provision, or the amount stipulated in any applicable legislation, if greater.

Disability Benefit

We will waive premiums for the member's dependant life insurance for a period during which the member's life insurance premiums are waived due to the member's disability.

Short Term Disability Insurance Provision

Definitions

Gross rate of earned income	means the regular standard weekly rate of earned income before income tax deductions, Employment Insurance contributions and Canada/Québec Pension Plan contributions.
Net rate of earned income	means the weekly rate of earned income after income tax deductions, Employment Insurance contributions and Canada/Québec Pension Plan contributions.
Qualifying period	means the period of continuous total disability, as determined in the Summary of Insurance, beginning on the date the member becomes totally disabled and ending on the date the member qualifies for benefits under this provision. During the qualifying period, the member may work on a modified or part-time basis. If this work arrangement is approved by us, it will not jeopardize the payment of weekly disability benefits. The qualifying period will not be extended by the amount of time worked.
Totally disabled and total disability	mean that, during and after the qualifying period, the member has a medical impairment due to injury or disease which prevents him from performing the essential duties of the occupation in which he participated just before the total disability started. The medical impairment must be supported by objective medical evidence. The availability of work for the member does not affect the determination of totally disabled or total disability.

Amount of Weekly Disability Benefit

All references to income under "Other Sources of Income" are to the gross amounts before any deductions.

The amount of weekly disability benefit is the lesser of 1. and 2. below:

1. An amount determined by applying the benefit formula specified in the Summary of Insurance to the member's weekly gross rate of earned income, rounded to the next higher $1.00, and limited to the maximum weekly benefit, less items 1 a., b. and c. listed under “Other Sources of Income”.
2. An amount equal to 100% of the member's weekly gross rate of earned income in force on the date he became totally disabled if the benefit is subject to income tax, or weekly net rate of earned income if the benefit is not subject to income tax, less items 1 a., b. and c. listed under “Other Sources of Income”.

Other Sources of Income

1. “Other Sources of Income” include disability and retirement income from the following sources:
   a. the Workers’ Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
   b. an automobile insurance policy.
   c. period of disability for which the member receives wages or vacation pay.

d. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.

2. "Other Sources of Income" do not include disability and retirement income from the following sources:

   a. a policy which is solely an individual disability income policy.
   b. a disability attachment to an individual life insurance policy.
   c. a retirement income plan providing income that becomes payable before the member becomes totally disabled, whether or not the retirement income is related to disability.

Payment of Weekly Disability Benefit

We will pay the member the amount of weekly disability benefit in force on the date the total disability began when we receive proof that he has been totally disabled for the qualifying period. Benefits are paid in advance and will begin one week after the member is entitled to receive benefits. A benefit equal to one-seventh of the amount of weekly disability benefit is payable for each full day he is totally disabled following the qualifying period.

If a member is absent from active work for more than half of his first day of total disability, the absence is considered one full day of total disability.

Benefits are payable from the later of

1. the end of the qualifying period,
2. the date the member is no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan, or
3. the date the member is no longer entitled to receive severance pay, payments in lieu of severance pay and damages, or settlements for wrongful dismissal.

Benefits are payable concurrently with any disability benefit the member is entitled to receive under the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.

Benefits are payable for members who are disabled on their scheduled date of return to active employment from an authorized leave of absence to attend a union education course and/or convention of not more than 14 calendar days or attendance at the Canadian Labour College, provided the member was attending such school while on a Company approved leave of absence. Benefits are payable from the scheduled date of return to active employment for a period not to exceed the maximum duration.

In the case of situational stress/depression resulting from serious or terminal illness of the spouse or dependant child, weekly indemnity will be provided for up to 4 months, if recommended by the attending physician.

Benefit payments stop on the earlier of the date the benefit period ends or the date that

1. the member is no longer totally disabled,
2. the member dies,
3. the member participates in any occupation for remuneration or profit or any educational program other than a rehabilitation program approved by us and Wabush Mines,
4. the member refuses to participate in a rehabilitation program approved by us and Wabush Mines, or a WCB, WSIB (or other similar board) approved rehabilitation program we consider to be reasonable,
5. the member refuses to participate in a vocational or functional capacities assessment,
6. the member is confined in a prison or similar institution,
7. the member fails to submit proof to us that he continues to be totally disabled,
8. the member fails to submit to an examination at our request, by an independent physician or a registered psychologist we appoint,

9. the member has been rehabilitated into a new or modified position, or
10. the member refuses to participate in modified or alternate work which accommodates the limitations of his total disability.

When the benefit period ends, the member's Short Term Disability Provision terminates. When he fully recovers and resumes his regular work schedule, that coverage will be reinstated upon request. No benefits are payable if, within 30 days of reinstatement, he becomes totally disabled due to the same or related causes as the previous total disability.

Consecutive Periods of Total Disability

If a member stops being totally disabled following a total disability for which benefits are payable and, within 30 days, he becomes totally disabled again from the same or related causes, or, within 20 days, he becomes totally disabled again from an unrelated cause, that total disability is considered to be a continuation of the previous total disability.

The amount and the payment of weekly disability benefits for consecutive periods of total disability are determined from the Short Term Disability Provision in force on the date the previous total disability began.

No weekly disability benefits are payable during a consecutive period of total disability if any group Long Term Disability benefit is available.

Subrogation (Reimbursement for Third Party Liability)

If we have paid or may be obligated to pay a benefit for an injury or disease for which a third party is or may be liable for damages either in whole or in part, we will assert our right to reimbursement, where permitted by law. We will require the member to sign and comply with a reimbursement agreement.

The member is obligated to reimburse us when the amount of weekly disability benefits paid, together with the amount recovered from the third party for lost income, exceeds 100% of the member's lost income. If the member recovers less than the entire loss, we are entitled to prorate our subrogated recovery.

The amount the member must reimburse us will not exceed the amount of weekly disability benefits paid.

If the member recovers an unallocated amount, the member will provide us with a reasonable breakdown of the recovered amount showing the amounts for past and future lost income and the interest on these amounts. If the member obtains a structured settlement, the member will provide us with a reasonable breakdown of that settlement.

We will not be bound by any settlement entered into between the member and the third party unless the member obtains our prior written consent.

If the member receives an amount for future loss of income, we will withhold weekly disability payments. We will apply the lump sum amount of the future loss award as an offset against the amount of weekly disability benefit. No further weekly disability benefits will be paid under the plan until such benefits, which would otherwise be payable under the plan, are equal to the amount recovered for future loss of income.

Claims

A claim must be received by us within 90 days after the date the member became totally disabled.

We may require

1. proof that the member continues to be totally disabled,
2. an examination by an independent physician or a registered psychologist appointed by us,
3. a vocational or functional capacities assessment, and
4. other information we consider necessary for the assessment of a claim.

Proof of claim is at the claimant's expense.

From time to time we may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the claimant may not be entitled to some or all benefit payments.

There is a time limit for appealing our decision to decline or terminate a claim. An appeal must be made within 3 years of such a decision and must be accompanied by new objective medical evidence.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or

2. regarding claims for disability benefits that we have paid for some period of time, more than one year after the last date for which disability benefits have been paid.

Exclusions and Limitations

No benefit is payable for a total disability due to or related to

1. intentionally self-inflicted injuries,
2. civil disorder or war, whether or not war was declared.

No benefit is payable during any leave of absence mutually agreed upon by the member and you, unless the law requires coverage for the health related portion of a maternity leave. A maternity leave of absence will begin on the earlier of the agreed leave date or the date of birth of the child.

No benefit is payable for loss of income due to elective cosmetic or experimental surgery unless the surgery or treatment is for accidental injuries or unless the surgery is medically necessary as determined by the provincial health care plan in the province where the member resides.

No benefit is payable if a member is absent from Canada longer than 3 weeks due to any reason, unless we agree in writing in advance to pay benefits during the period.

A member is not considered totally disabled unless he is under the active and continuous care of a physician whom we consider to be appropriate to the member's total disability and he is following the treatment prescribed by that physician.

A member is not considered totally disabled due to the use of drugs or alcohol unless he is being actively supervised by and is receiving continuous treatment for that total disability from a rehabilitation centre or an institution provincially designated for that treatment.

Long Term Disability Insurance Provision

Definitions

Gross Regular Standard Monthly Wage	means the regular standard monthly wage before income tax deductions, Employment Insurance contributions and Canada/Québec Pension Plan contributions.
Net Regular Standard Monthly Wage	means the regular standard monthly wage after income tax deductions, Employment Insurance contributions and Canada/Québec Pension Plan contributions.
Qualifying period	means the period of continuous total disability, as determined in the Summary of Insurance, beginning on the date the member becomes totally disabled and ending on the date the member qualifies for benefits under this provision. During the qualifying period, the member may work on a modified or part-time basis. If this work arrangement is approved by us, it will not jeopardize the payment of monthly disability benefits. The qualifying period will not be extended by the amount of time worked.
Regular Standard Monthly Wage	means the earnings calculated in accordance with the hourly wage rate for the highest job class in which the member worked for a period of at least 6 months during the two years preceding his disability unless he was voluntarily reduced, in which case, the standard hourly wage rate of his regular job at the time of disability, times 2,080 hours, divided by 12.
Totally disabled and total disability	mean that, during the qualifying period and the 24 month period immediately following it, the member has a medical impairment due to injury or disease which prevents him from performing any and every duty relating to his regular job in which he participated just before the total disability started. After the 24 month period, totally disabled and total disability mean that the member is unable to engage in any employment of the type covered by the Collective Agreement and his total disability is deemed to be permanent and continuous during the remainder of his life. The medical impairment must be supported by objective medical evidence. The availability of work for the member does not affect the determination of totally disabled or total disability.

Amount of Monthly Disability Benefit

All references to income under "Other Sources of Income" are to the gross amounts before any deductions.

The amount of monthly disability benefit is an amount equal to the member’s gross regular standard monthly wage in force on the date he became totally disabled if the benefit is subject to income tax, or net regular standard monthly wage if the benefit is not subject to income tax, less items 1 a., b. and c. listed under "Other Sources of Income".

Other Sources of Income

1. "Other Sources of Income" include disability and retirement income from the following sources:

    a. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
    b. a retirement income plan providing income from Wabush Mines Pension Plan that becomes payable after the member is no longer actively at work, whether or not the retirement income is related to disability.
    c. the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as disability or retirement income.

    Increases in the disability income payable under a government plan may occur because of an automatic adjustment in the cost of living. These increases will not further reduce the amount of monthly disability benefit.

    Total income from all sources will not be less than the amount of monthly disability benefit for which the member is insured.

2. "Other Sources of Income" do not include disability and retirement income from the following sources:
    a. a policy which is solely an individual disability income policy.
    b. a disability attachment to an individual life insurance policy.
    c. a retirement income plan providing income that becomes payable before the member becomes totally disabled, whether or not the retirement income is related to disability.
    d. the Canada/Québec Pension Plan or a similar pension plan, excluding benefits for dependent children.

Rehabilitation

Rehabilitation is not an entitlement under this provision. If a member qualifies for benefits under this provision, we may consider a rehabilitation program, limited to one or more of:

1. assessment,
2. counselling,
3. vocational retraining or an education program,
4. trial work, part-time work or modified work.

A rehabilitation program must be approved by us, Wabush Mines and by a physician who has examined the member. The decision to approve a rehabilitation program is based on the duration and nature of rehabilitation required for the earliest possible return to remunerative employment. Expenses related to the approved rehabilitation program must be given prior approval by us.

A member participating in a rehabilitation program approved by us continues to be considered totally disabled.

If, after qualifying for benefits under this provision, a member is receiving income under an approved rehabilitation program, his amount of monthly disability benefit is reduced by 50% of that income. The amount of monthly disability benefit is further reduced so that the total income from all sources does not exceed 100% of the member's monthly

1. gross rate of earned income in force on the date he became totally disabled, if the benefit is subject to income tax, or

2. net rate of earned income in force on the date he became totally disabled, if the benefit is not subject to income tax.

Payment of Monthly Disability Benefit

We will pay the member the amount of monthly disability benefit in force on the date the total disability began when we receive proof that he has been totally disabled from the same or related causes for the qualifying period. Benefits are paid in arrears and will begin one month after the member is entitled to receive benefits. A benefit equal to one-thirtieth of the amount of monthly disability benefit is payable for each full day he is totally disabled following the qualifying period.

Benefits are payable from the later of

1. the end of the qualifying period,
2. the date the member is no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan, or
3. the date the member is no longer entitled to receive severance pay, payments in lieu of severance pay and damages, or settlements for wrongful dismissal.

Benefit payments stop on the earlier of the date the benefit period ends or the date that

1. the member is no longer totally disabled,
2. the member dies,
3. the member participates in any occupation for remuneration or profit or any educational program other than a rehabilitation program approved by us,
4. the member refuses to participate in a rehabilitation program approved by us, or a Worker's Compensation, Workplace Safety and Insurance Act or similar legislation approved rehabilitation program we consider to be reasonable,
5. the member refuses to participate in a vocational or functional capacities assessment,
6. the member is confined in a prison or similar institution,
7. the member fails to submit proof to us that he continues to be totally disabled,
8. the member fails to submit to an examination at our request, by an independent physician or a registered psychologist we appoint,
9. the member has been rehabilitated into a new or modified position, or
10. the member refuses to participate in modified or alternate work which accommodates the limitations of his total disability.

When the benefit payments stop, the member's Long Term Disability Insurance terminates. When he returns to active work, that insurance will be reinstated upon request.

Consecutive Periods of Total Disability

If a member stops being totally disabled while satisfying a qualifying period and, within 30 days, he becomes totally disabled again from the same or related causes, that total disability is considered to be a continuation of the previous total disability.

If a member stops being totally disabled following a total disability for which benefits are payable and within 6 months, he becomes totally disabled again from the same or related causes, or at least 3 months in case of an unrelated cause, that total disability is considered to be a continuation of the previous total disability.

The amount and the payment of monthly disability benefits for consecutive periods of total disability are determined from the Long Term Disability Insurance Provision in force on the date the previous total disability began.

Subrogation (Reimbursement for Third Party Liability)

If we have paid or may be obligated to pay a benefit for an injury or disease for which a third party is or may be liable for damages either in whole or in part, we will assert our right to reimbursement, where permitted by law. Before benefit payments are made, we will require the member to sign and comply with a reimbursement agreement.

The member is obligated to reimburse us when the amount of monthly disability benefits paid, together with the amount recovered from the third party for lost income, exceeds 100% of the member's lost income. If the member recovers less than the entire loss, we are entitled to prorate our subrogated recovery.

The amount the member must reimburse us will not exceed the amount of monthly disability benefits paid.

If the member recovers an unallocated amount, the member will provide us with a reasonable breakdown of the recovered amount showing the amounts for past and future lost income and the interest on these amounts. If the member obtains a structured settlement, the member will provide us with a reasonable breakdown of that settlement.

We will not be bound by any settlement entered into between the member and the third party unless the member obtains our prior written consent.

If the member receives an amount for future loss of income, we will withhold monthly disability benefits. We will apply the lump sum amount of the future loss award as an offset against the amount of monthly disability benefit. No further monthly disability benefits will be paid under the policy until such benefits, which would otherwise be payable under the policy, are equal to the amount recovered for future loss of income.

Claims

A claim must be received by us within 3 months after the end of the qualifying period.

We may require

1. proof that the member continues to be totally disabled,
2. an examination by an independent physician or a registered psychologist appointed by us,
3. proof of the member's age,
4. a vocational or functional capacities assessment, and
5. other information we consider necessary for the assessment of a claim.

Proof of claim is at the claimant's expense.

From time to time we may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the claimant may not be entitled to some or all benefit payments.

There is a time limit for appealing our decision to decline or terminate a claim. An appeal must be made within 3 years of such a decision and must be accompanied by new objective medical evidence.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or

2. regarding claims for disability benefits that we have paid for some period of time, more than one year after the last date for which disability benefits have been paid.

Exclusions and Limitations

No benefit is payable for a total disability due to or related to

1. intentionally self-inflicted injuries,
2. civil disorder or war, whether or not war was declared,
3. services in the armed forces of any country,
4. participation in any criminal act,
5. if the disability was contracted, suffered or received while the member was engaged in, or resulted from his being engaged in, any service, occupation or employment for remuneration or profit while on leave of absence from the company's service.

A member is not considered totally disabled unless he is under the active and continuous care of a physician whom we consider to be appropriate to the member's total disability and he is following the treatment prescribed by the physician.

A member is not considered totally disabled due to the use of drugs or alcohol unless he is being actively supervised by and is receiving continuous treatment for that disability from a rehabilitation centre or an institution provincially designated for that treatment.

Waiver of Premiums

We will waive premiums for the member's Long Term Disability Insurance while he is eligible to receive benefit payments.

Extended Health Insurance Provision

Claims

A claim must be received by us within 18 months of the date that the expense is incurred. However, if coverage for a member terminates, any claim must be received by us no later than 90 days following the end of the coverage.

For the assessment of a claim, we may require itemized bills, attending physician statements or other information we consider necessary. Proof of claim is at the claimant's expense.

From time to time we may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the claimant may not be entitled to some or all benefit payments.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or

2. regarding claims for which we have made some payment, more than one year after we have made the last payment with respect to the claim.

Payment of Benefits

To qualify for the Extended Health coverage, the member or his dependant must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

We will reimburse a member when we receive proof that he or his insured dependant has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or injury. Eligible expenses for the services of a practitioner include only those services which are performed within his area of expertise and require the skills and qualifications of such a practitioner.

The maximums described throughout the Extended Health Insurance Provision are eligible expense maximums which are reduced by the deductible and reimbursement percentage shown on the Summary of Insurance before payment is made. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the eligible expense maximums are applied,
2. the deductible, which must be satisfied each calendar year, is subtracted, and
3. the reimbursement percentage is applied.

Subrogation

If we have paid a benefit for an injury or disease for which any third party is or may be liable for damages, we will be subrogated to the rights of the member against the third party, where permitted by law.

We will require the member to sign an undertaking to reimburse us. Reimbursement is required when the amount of medical and/or dental expenses paid, together with the amount recovered from the third party, exceed 100% of the actual cost of these expenses. The amount the member must reimburse will not be greater than the amount of benefits paid.

We will not be bound by any compromised settlement entered into between the member and the third party unless the member obtains our consent to the settlement.

If the member is awarded a lump sum for future medical and/or dental expenses under a judgment or settlement, medical and/or dental benefits will be subject to our subrogated right of reimbursement, until such time as the amount of benefits that would have been paid equals the amount received in the lump sum.

Co-ordination of Benefits

If a member or dependant is covered under this plan and another plan, our benefits will be co-ordinated with the other plan following insurance industry standards. These standards determine which plan the member should claim from first.

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

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

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

Claims for the member or spouse should be submitted in the following order:

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

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

When a member submits a claim, the member has an obligation to disclose to Sun Life all other equivalent coverage that the member or the member's dependants have.

Exclusions

No benefit is payable for

1. expenses for which benefits are payable under a Workers' Compensation Act, Automobile Insurance Act, Workplace Safety and Insurance Act or a similar statute,
2. expenses incurred due to intentionally self-inflicted injuries,
3. expenses incurred due to civil disorder or war, whether or not war was declared,
4. expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
5. expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with Government Programs*,
6. expenses for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
7. expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
8. expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
9. out-of-province expenses for elective (non-emergency) medical treatment or surgery,
10. expenses for which individual is not required to pay.

Integration with Government Programs

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

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

1. whether the member or his dependant has made an application to the government program,
2. whether coverage under this plan affects the member's or his dependant's eligibility or entitlement to any benefits under the government program, or
3. any waiting lists.

Benefits After Termination of a Member's Insurance

If the member dies, the pensioned surviving spouse of an active employee and dependants are insured for Extended Health Insurance in the applicable Summary of Insurance, until the surviving spouse remarries, becomes a dependant of another person in a common-law relationship or otherwise becomes insured elsewhere. Pensioned surviving spouse of a retiree is entitled to the drug plan only.

Extended Health - Comprehensive Drug Benefit (Divisions 5, 6 and 25)

Definitions

Dentist	means a person licensed to practise dentistry by the provincial licensing authority.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.
Registered pharmacist	means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription
3. injectible drugs, including vitamins and allergy extracts.
3. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
4. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
4. drugs that are not scheduled federally, but have provincial restrictions.
5. colostomy supplies.

Régie de l'assurance-maladie du Québec (RAMQ) Formulary Drugs for Québec Residents

In addition to the above eligible expenses, this benefit includes all drugs covered by Québec's basic drug formulary, as established by the RAMQ. The minimum reimbursement percentage required by provincial legislation is applied up to the annual out-of-pocket maximum, as specified by law. This formulary is reviewed on a regular basis and is subject to change as new drugs and drug products are introduced.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Exclusions

No benefit is payable for

1. expenses for contraceptives (other than oral),
2. expenses for vitamins, minerals, protein supplements and therapeutic nutrients,
3. expenses for diets and dietary supplements, infant foods and sugar or salt substitutes,
4. expenses for lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives or emollients,
5. expenses for surgical supplies and diagnostic aids,
6. expenses for drugs which are used for cosmetic purposes,
7. atomizers, appliances, prosthetic devices, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as “Glucometer”), non-disposable insulin delivery devices (such as “Novolin Pen”), delivery or extension devices for inhaled medications (such as “Rotohaler”, “Diskhaler”, “Aerochamber”), spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, or supplies and accessories for the aforementioned,
8. proprietary medicines which bear a general product (GP) number, as defined in Division 10 of the Food and Drug Act,
9. prescriptions dispensed by a doctor, dentist, clinic or in any non-accredited hospital pharmacy, including investigational status drugs and emergency status drugs,
10. all allergy extracts not bearing a drug identification number,
11. homeopathic preparations,
12. expenses for drugs used for the treatment of sexual dysfunction,
13. expenses for drugs used for the treatment of obesity,
14. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
15. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
16. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Pay Direct Drug Benefit (Divisions 2, 4, 15, 16, 17, 18, 26, 27, 40 and 115)

Definitions

Dentist	means a person licensed to practise dentistry by the provincial licensing authority.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.
Registered pharmacist	means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible.

1. drugs which legally require a prescription
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
6. colostomy supplies.
7. for division 115, expenses for smoking cessation aids that require a prescription, limited to a calendar year maximum of $500 for the member and each insured dependant.

Drug Substitution Limit

Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require the insured person and the attending doctor to complete and submit an exception form.

For members and insured dependants who live in Québec, this limit only applies as long as the drug expenses actually paid by the plan are not lower than the minimum set by the Régie de l'assurance-maladie du Québec and the out-of-pocket maximum for prescription drug expenses has not been reached.

Régie de l'assurance-maladie du Québec (RAMQ) Formulary Drugs for Québec Residents

In addition to the above eligible expenses, this benefit includes all drugs covered by Québec's basic drug formulary, as established by the RAMQ. The minimum reimbursement percentage required by provincial legislation is applied up to the annual out-of-pocket maximum, as specified by law. This formulary is reviewed on a regular basis and is subject to change as new drugs and drug products are introduced.

Members age 65 and over who are covered by the Régie de l'assurance-maladie du Québec (RAMQ) – Division 17 only

The following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

- ·The coinsurance amount and the deductible that the member must pay under their RAMQ plan are eligible and will be reimbursed at the reimbursement level of this plan.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
3. expenses for drugs which, in our opinion, are experimental,
4. expenses for dietary supplements, vitamins and infant foods,
5. expenses for contraceptives (other than oral),
6. expenses for drugs which are used for cosmetic purposes,
7. expenses for drugs used for the treatment of sexual dysfunction,
8. for division 15, expenses for smoking cessation aids,
9. expenses for drugs used for the treatment of obesity,
10. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
11. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
12. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Pay Direct Drug Benefit (Divisions 1, 20 and 30)

Definitions

Dentist	means a person licensed to practise dentistry by the provincial licensing authority.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.
Registered pharmacist	means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
6. colostomy supplies.
7. smoking cessation aids, nicotine patches and Zyban are covered up to one treatment lifetime and a maximum of $500.

Drug Substitution Limit

Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require the insured person and the attending doctor to complete and submit an exception form.

limit only applies as long as the drug expenses actually paid by the plan are not lower than the minimum set by the Régie de l'assurance-maladie du Québec and the out-of-pocket maximum for prescription drug expenses has not been reached.

Régie de l'assurance-maladie du Québec (RAMQ) Formulary Drugs for Québec Residents

In addition to the above eligible expenses, this benefit includes all drugs covered by Québec's basic drug formulary, as established by the RAMQ. The minimum reimbursement percentage required by provincial legislation is applied up to the annual out-of-pocket maximum, as specified by law. This formulary is reviewed on a regular basis and is subject to change as new drugs and drug products are introduced.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your insured dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
3. expenses for drugs which, in our opinion, are experimental,
4. expenses for dietary supplements, vitamins and infant foods,
5. expenses for contraceptives (other than oral),
6. expenses for drugs which are used for cosmetic purposes,
7. expenses for drugs used for the treatment of sexual dysfunction,
8. expenses for drugs used for the treatment of obesity,
9. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
10. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
11. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Pay Direct Drug Benefit (Division 105)

Definitions

Dentist	means a person licensed to practise dentistry by the provincial licensing authority.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.
Registered pharmacist	means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible.

1. drugs which legally require a prescription.
2. injectible drugs.
3. compounded prescriptions where one of the ingredients is an eligible expense.
4. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which, in our opinion, are experimental,
3. expenses for dietary supplements, vitamins and infant foods,
4. expenses for contraceptives (other than oral),
5. expenses for drugs which are used for cosmetic purposes,
6. expenses for drugs used for the treatment of sexual dysfunction,
7. expenses for drugs used for the treatment of obesity,
8. expenses for vaccines,
9. expenses for natural health products, whether or not they have a Natural Product Number (NPN),

10. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
11. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Pay Direct Drug Benefit (Division 125)

Definitions

Dentist	means a person licensed to practise dentistry by the provincial licensing authority.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.
Registered pharmacist	means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible.

1. drugs which legally require a prescription.
2. injectible drugs.
3. compounded prescriptions where one of the ingredients is an eligible expense.
4. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
5. smoking cessation drugs which do not legally require a prescription, limited to a calendar year maximum of $400.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which, in our opinion, are experimental,
3. expenses for dietary supplements, vitamins and infant foods,
4. expenses for contraceptives (other than oral),
5. expenses for drugs which are used for cosmetic purposes,
6. expenses for drugs used for the treatment of sexual dysfunction,
7. expenses for drugs used for the treatment of obesity,
8. expenses for vaccines,

9. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
10. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
11. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Vision Care Benefit

Definitions

Ophthalmologist	means a person licensed to practise ophthalmology.
Optometrist	means a member of the Canadian Association of Optometrists or of a provincial association associated with it.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses are the reasonable and customary charges for eyeglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Insurance for eligible expenses incurred during a 24 month period for the member and for each insured dependant.

Exclusions

No benefit is payable for expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Supplementary Hospital Benefit

Definitions

Convalescent and Chronic Care Hospital	means a legally licensed hospital with beds or units designated for chronic care and which provides facilities for diagnosis, care and treatment of a person suffering from disease or injury on a 24 hour basis, with 24 hour services by registered nurses and physicians. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Hospital	means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses, and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for

1. accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization and a maximum of 730 days per disability.
2. semi-private accommodation in a convalescent or chronic care hospital provided confinement occurs immediately following confinement in a legally constituted hospital, and confinement is prescribed by a physician.

Exclusions

No benefit is payable for expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Ambulance Services (Divisions 1, 16, 17, 18, 20 and 30)

Definitions

Convalescent and Chronic Care Hospital	means a legally licensed hospital with beds or units designated for chronic care and which provides facilities for diagnosis, care and treatment of a person suffering from disease or injury on a 24 hour basis, with 24 hour services by registered nurses and physicians. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Hospital	means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses, and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for

1. licensed ground ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, limited to $150 per confinement.
2. air ambulance:
   a. stretcher case - in the event the patient is a stretcher case, air ambulance charges will cover travel by the patient and one attendant out of Wabush Labrador, to the nearest legally constituted hospital where treatment is available and the patient's return from the hospital to Wabush Labrador, as prescribed by a physician.
   b. non-stretcher case - air ambulance charges will cover travel by the patient out of Wabush, Labrador and the return of the patient to Wabush, Labrador. Charges include the return air fare (both ways) for any hospitalization of a patient to the nearest hospital, convalescent or recognized treatment center for treatments where treatment is available whether in the case of a "stretcher" or in "non-stretcher" cases. The return air fare for one parent or guardian accompanying a dependant child up to the age of sixteen (16) inclusive is also covered.

   In order to qualify for such benefit, the following criteria must be met:
   - the medical service is not available in the immediate area;
   - the patient is referred by a licensed physician to the nearest facility, or specialist, capable of rendering the special services;
   - the service is deemed by the attending physician to be necessary at the time the patient goes, i.e. not elective.

   Air ambulance charges will not be considered if the services were provided while the patient was on vacation for which an "Air Transportation Allowance" was paid.

This air ambulance benefit will cover up to a maximum of $750 per hospital confinement, excluding any government and local hospital subsidies, when applicable.

For all successive periods of illnesses due to the same or related cause or causes, in the case of a dependant, the dependant has resumed normal activity for a period of 1 month.

Exclusions

No benefit is payable for expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Ambulance Services (Divisions 2, 4, 6, 26, 27 and 40)

Definitions

Convalescent and Chronic Care Hospital	means a legally licensed hospital with beds or units designated for chronic care and which provides facilities for diagnosis, care and treatment of a person suffering from disease or injury on a 24 hour basis, with 24 hour services by registered nurses and physicians. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Hospital	means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses, and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for

1. licensed ground ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, limited to $150 per confinement.
2. air ambulance:
   a. stretcher case - in the event the patient is a stretcher case, air ambulance charges will cover travel by the patient and one attendant out of Sept-Iles, to the nearest legally constituted hospital where treatment is available and the patient's return from the hospital to Sept-Iles, as prescribed by a physician.
   b. non-stretcher case - air ambulance charges will cover travel by the patient out of Sept-Iles, and the return of the patient to Sept-Iles. Charges include the return air fare (both ways) for any hospitalization of a patient to the nearest hospital, convalescent or recognized treatment center for treatments where treatment is available whether in the case of a "stretcher" or in "non-stretcher" cases. The return air fare for one parent or guardian accompanying a dependant child up to the age of sixteen (16) inclusive is also covered.

   In order to qualify for such benefit, the following criteria must be met:
   - the patient must be hospitalized for at least 18 hours;
   - the medical service is not available in the immediate area;
   - the patient is referred by a licensed physician to the nearest facility, or specialist, capable of rendering the special services;
   - the service is deemed by the attending physician to be necessary at the time the patient goes, i.e. not elective.

This air ambulance benefit will cover up to a maximum of $750 per hospital confinement, excluding any government and local hospital subsidies, when applicable.

For all successive periods of illnesses due to the same or related cause or causes, in the case of a dependant, the dependant has resumed normal activity for a period of 1 month.

Exclusions

No benefit is payable for expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Supplementary Health Care Benefit

Definitions

Acupuncturist	means a person who is listed on the appropriate provincial registry.
Chiropractor	means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.
Hospital	means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
Physiotherapist	means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.
Psychologist	means a permanently certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.
Registered Massage Therapist	means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications we determine to be comparable with those required by a licensing body.
Registered Nurse/ Registered Nursing Assistant/Licensed Practical Nurse/ Registered Practical Nurse	means a nurse, nursing assistant or practical nurse who is listed on the appropriate provincial registry.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician, unless otherwise specified.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.), registered nursing assistant (R.N.A.), licensed practical nurse (L.P.N.) or registered practical nurse (R.P.N.) when provided in the patient's home. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., L.P.N., or R.P.N.

2. **for divisions 1, 2, 30 and 40**: the services of the following practitioners, limited to a maximum of $35 per visit and a calendar year maximum of 20 visits for all practitioners combined.

   - a chiropractor*,
   - a physiotherapist*,
   - a psychologist,
   - a registered massage therapist, and
   - an acupuncturist*.

   *physician's prescription not required.

   for all other divisions: the services of the following practitioners, limited to a maximum of $25 per visit and a calendar year maximum of 20 visits for all practitioners combined.

   - a chiropractor*,
   - a physiotherapist*,
   - a psychologist, and
   - a registered massage therapist.

   *physician's prescription not required.

   Where applicable, expenses for practitioners' services eligible under a provincial health care plan will not be reimbursed until expenses exceed the annual maximums under the member's or insured dependant's provincial plan.

3. the services of a psychiatrist while the member is not totally disabled or if the dependent is not confined in a hospital, sanatorium or similar institution, reimbursed at 50%. In all other circumstances, the services of a psychiatrist are reimbursed at the co-insurance of the plan.

4. services of a dentist required for treatment of accidental injuries to natural teeth within 6 months of the accident where injury was caused by external, violent and accidental means. Such accidental injuries must be suffered while insured under this plan.

5. the excess of $150 for professional ground ambulance services, excluding any government and local hospital subsidies, will be reimbursed provided the member qualifies for the Air Ambulance benefit under the Extended Health - Ambulance Services clause.

6. the excess of $750 for air ambulance services (except stretcher cases), excluding any government and local hospital subsidies, will be reimbursed provided the member qualifies for the Air Ambulance benefit under the Extended Health - Ambulance Services clause.

7. artificial limbs or other prosthetic appliances.

8. oxygen.

9. diagnostic laboratory and x-ray examinations, including radium treatments. Periodic physical examinations are excluded.

10. blood glucose monitors.

11. blood pressure monitors, limited to $150 per five year period.

12. rental, or purchase at our option, of an iron lung or other durable equipment that meets the patient's basic medical needs and is approved by us. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs.

13. blood transfusions and plasma.

14. elastic stockings, limited to 4 pairs per calendar year.

15. cosmetic surgery or treatment necessary for correction of damage caused by accidental means.

16. charges for semi-private accommodation in a hospital, limited to the difference between the charges for public ward and semi-private accommodation for each day of hospitalization, starting from the 731st day of hospitalization.
17. anaesthetics and the administration thereof.
18. insulin pumps, which are required for therapeutic use and approved by us.

Exclusions

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the use of a service,
5. hearing aids and examinations for the prescription or fitting thereof,
6. health check-ups and routine physical examinations,
7. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health - Out-of-Province Emergency Benefit in Canada

Definitions

Emergency	means a sudden, unexpected occurrence (disease or injury) that requires immediate medical attention. This includes treatment (non-elective) for immediate relief of severe pain, suffering or disease which cannot be delayed until the member or insured dependant returns to his province of residence.
Hospital	means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour service by registered nurses and physicians.
Reasonable and customary charges	mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

To be covered for the Out-of-Province Emergency Benefit in Canada, a member and his insured dependant must have provincial health care insurance. Expenses for hospital/medical services are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside the member's or dependant's province of residence,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 180 days of travelling on vacation or business outside the member's or dependant's province of residence. The 180 day travel period starts on the first day of departure.

Eligible Expenses for Hospital/Medical Services

Eligible expenses mean reasonable and customary charges for the following items of expense, less the amount payable by a government plan:

1. public ward accommodation and auxiliary hospital services in a general hospital,
2. services of a physician,
3. economy air fare for the patient's return to his province of residence for medical treatment,
4. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment in Canada, when the patient's physical condition prevents the use of another means of transportation,
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment in Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

The maximum lifetime amount payable for the above Eligible Expenses is $1,000,000 for the member and for each insured dependant.

Expenses that are included as Eligible Expenses under Drug, Vision, Hospital or Supplementary Health Care benefits are also eligible while the member is travelling in Canada. These expenses are subject to the deductibles and reimbursement percentages listed under the appropriate benefit in the Summary of Insurance.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by the member or his insured dependant for an emergency which occurs more than 180 days after departure from his province of residence,
2. expenses for the regular treatment of an injury or disease which existed before the member's or dependant's departure from his province of residence,
3. expenses incurred on a non-emergency or referral basis,
4. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Insurance Provision.

If your group plan provides insurance for retirees, the retired employee and his insured dependants must return to his province of residence for at least 30 consecutive days before he becomes eligible for another 180 days of coverage.

Dental Insurance Provision

Definitions

Dental hygienist means a person licensed by the appropriate provincial authority to practice dental hygiene. Where required by law, services must be performed under the supervision of a dentist.

Dentist means a person licensed to practice dentistry by the provincial licensing authority.

Denturist means a person licensed by the appropriate provincial authority to work as a practitioner directly supplying and fitting dentures to the public.

Fee guide refers to

1. for services provided by dentists, the charges established for general practitioners by the provincial dental association in the province where the expense is incurred,
2. for services provided by dental specialists and for services that are within the dental specialist's area of specialization, the charges established by the provincial society of dental specialists in the province where the expense is incurred,
3. for services provided by denturists, the lesser of
   a. the charges, established by the provincial organization of denturists in the province where the expense is incurred, or
   b. the charges in (1) above.

Necessary Treatment means the performance of procedures, services, courses of treatment and the use of materials which are

1. necessary and appropriate in relation to current, accepted standards of dental practice,
2. performed by a dentist, a dental hygienist or a denturist, and
3. of a form, frequency and duration essential to the management of the person's dental health

Reasonable and customary charges mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the charges in the Dental Fee Guide specified in the Summary of Insurance.

Time Unit means 15 minutes.

Claims

A claim must be received by us within 18 months of the date the expense is incurred. However, if coverage for a member terminates, any claim must be received by us no later than 90 days following the end of the coverage.

For the assessment of a claim, we may require itemized bills, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other information we consider necessary. Proof of claim is at the claimant's expense.

From time to time we may request additional information to support a proof of claim. If the information is not provided within 90 days of the request, the claimant may not be entitled to some or all benefit payments.

We reserve the right to refuse any assignment of benefits under this provision.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against us:

1. regarding any claims for which we have not made any payment, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the policy, or
2. regarding claims for which we have made some payment, more than one year after we have made the last payment with respect to the claim.

Payment of Benefits

We will reimburse the member when we receive proof that he or his insured dependant has incurred any of the eligible expenses for necessary dental services performed by:

1. a dentist,
2. a dental hygienist, or
3. a denturist.

The maximums specified in the Summary of Insurance are payable maximums. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the deductible, which must be satisfied each calendar year, is subtracted,
2. the reimbursement percentage is applied,
3. the maximum amount payable is applied.

The Canadian Dental Association Procedure Codes are provided for identification of the individual treatment procedures included in each eligible expense of this provision. If a province does not use the Canadian Dental Association Procedure Codes, the procedure codes in the fee guide of that province, for the same procedure, will apply.

If we cannot determine that the expenses incurred are eligible expenses, or if there is a change in the Canadian Dental Association Procedure Codes, payment may be based on the cost of similar services which are eligible expenses.

Alternate Benefit

We reserve the right to take into account alternate procedures, services, courses of treatment and materials, and to provide dental benefits based on the least costly procedure, service, course of treatment and materials which will produce a professionally adequate result that is consistent with current, accepted standards of dental practice.

Subrogation

If we have paid a benefit for an injury or disease for which any third party is or may be liable for damages, we will be subrogated to the rights of the member against the third party, where permitted by law.

We will require the member to sign an undertaking to reimburse us. Reimbursement is required when the amount of dental expenses paid, together with the amount recovered from the third party, exceeds 100% of the actual cost of these expenses. The amount the member must reimburse will not be greater than the amount of benefits paid.

We will not be bound by any compromised settlement entered into between the member and the third party unless the member obtains our consent to the settlement.

If the member is awarded a lump sum for future dental expenses under a judgment or settlement, dental benefits will be subject to our subrogated right of reimbursement, until such time as the amount of benefits that would have been paid equals the amount received in the lump sum.

Co-ordination of Benefits

If a member or dependant is covered under this plan and another plan, our benefits will be co-ordinated with the other plan following insurance industry standards. These standards determine which plan the member should claim from first.

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

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

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

Claims for the member or spouse should be submitted in the following order:

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

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,

3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

When a member submits a claim, the member has an obligation to disclose to Sun Life all other equivalent coverage that the member or the member's dependants have.

Exclusions and Limitations

No benefit is payable for

1. expenses for which benefits are payable under a Workers' Compensation Act, Automobile Insurance Act, Workplace Safety and Insurance Act or a similar statute,
2. expenses incurred due to intentionally self-inflicted injuries,
3. expenses incurred due to civil disorder or war, whether or not war was declared,
4. expenses for services performed by a person who is ordinarily resident in the patient's home or who is closely related to the patient by blood or marriage,
5. expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit,
6. supplies which were first prescribed or recommended prior to the date on which the member would otherwise become insured hereunder for reimbursement in respect of such supplies,
7. charges for completion of claim forms,
8. charges for oral hygiene instruction, nutritional counselling or protective athletic appliances,
9. charges for appointments broken without notice.

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with, as specified in the Summary of Insurance.

Dental Insurance - Diagnostic/Preventive Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) examination and diagnosis	
– oral examination (once every 6 months)	01101-01103,01201,01206
– recall examination	01202
– limited periodontal examination	01203
– special oral examination	01204,01205,01301,01401,01402,01501, 01502,01601,01602,01701,01703,01801, 01802,01901,01902
– post mortem examination	95105
(b) tests and laboratory examinations	
– microbiological	04101
– biopsy of oral tissue	04311-04313,04321-04323
– cytological	04401,04402
– pulp vitality tests	04501,04509
– laboratory reports	04601-04603
(c) radiographs	
– complete series	02101,02102
– periapical	02111-02125
– occlusal	02131-02136
– bitewing (twice every 12 months)	02141-02146
– extraoral	02201-02204,02209
– skull and facial bone	02301-02304,02309
– sialography	02401,02402,02409
– radiopaque dyes to demonstrate lesions	02411,02412,02419
– temporomandibular joint dysfunction	02501-02504,02509
– panoramic	02601
– cephalometric radiographs	02751,02752,02759
– interpretation of radiographs received from another source	02801,02802,02809
– duplicate radiographs	02911-02919
(d) preventive services	
– dental polishing (twice every 12 months)	11101,11107
– preventive scaling	11111,11117

– topical application of fluoride phosphate (twice every 12 months)	12101
(e) control of oral habits	
– appliances	14101,14102,14103,14201,14202
(f) space maintainers	15101-15105,15201,15202,15301,15302, 15401-15403,15501,15601,15602
(g) laboratory procedures	99111,99333
(h) anaesthesia (if performed in conjunction with oral or periodontal surgery, fractures or dislocations)	
– general anaesthesia	92212-92219
– facilities	92222-92229
– deep sedation	92301-92309
– conscious sedation	92101,92102,92411-92419,92421-92429, 92431-92439,92441-92449,92451-92459, 92461-92469
(i) prescriptions	96101-96103
(j) therapeutic injections	96201,96202

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement of space maintainers which have been lost, stolen or mislaid,
3. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Restorative Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) restorations	
– amalgam	21111-21115,21211-21215,21221-21225, 21401-21405
– acrylic or composite resin	23101-23105,23111-23115,23211-23215, 23221-23225,23311-23315,23321-23325, 23401-23405,23411-23415,23501-23505, 23511-23515
(b) surgical services	
– uncomplicated removals	71101,71109
– surgical removals and repositioning	71201,71209,72111,72119,72211,72219, 72221,72229,72231,72239,72311,72319, 72321,72329,72331,72339
(c) major surgery	
– exposure of teeth	72511,72519,72521,72529,72531,72539, 72541,72551,72631,72639,72711,72719
– alveoloplasty	73142,73151-73154,73161,73171,73172, 73211,73221-73224,73231,73411
– surgical excision	74111-74118,74121-74128,74631-74638
– tumors	74211-74218,74221-74228
– enucleation of cyst	74611-74618,74621
– surgical incision	75111-75113,75121-75123
– extraoral absesses	75211,75212,75221
– fractures and reductions	76113,76201-76204,76301-76305,76401-76403,76503-76505,76601,76602-76605, 76701,76702,76911-76913,76921-76924, 76931-76934
– lacerations	76961-76969,76971-76979,76981-76989
– frenectomy	77801-77806
– glossectomy	77901,77902
– dislocations	78102,78103
– treatment of salivary glands	79101-79104,79111,79113,79123,79124
– miscellaneous surgical services	79601-79604
(d) laboratory procedures	99111,99333

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Orthodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense for dependent children under age 19 -

Procedures	Canadian Dental Association Procedure Codes
(a) observation, adjustment	
– observation, adjustment	80601,80602
– repairs, alterations	80631,80632,80639,80641,80642,80649, 80651,80659,80661,80669,80671,80679
– active appliances for tooth guidance or uncomplicated tooth movement	81111-81116,81121-81124,81131-81135, 81141-81144,81151-81154,81161-81164, 81211,81212,81221,81222,81231,81232, 81241-81243,81251-81254,81261-81264, 81271-81274,81281,81291-81294
– retention appliances	83101-83103,83201,83202
(b) comprehensive treatment	84101,84201,84301,84401,85101,85201, 85301,86101,86201,86301,87101,87201, 87301,88101,88201,88301,89101,89201, 89301,89501-89506
(c) laboratory procedures	99111,99333

Exclusions

No benefit is payable for

1. expenses for replacement of orthodontic appliances which have been lost, stolen or mislaid.
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Periodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) preventive services	
– oral hygiene group instruction	13221-13224,13227
(b) periodontics	
– non surgical services	41101-41104,41109,41211-41214,41219, 41221-41224,41229,41231-41234,41239, 41301,41302,41309
– occlusal adjustment/equilibration (not exceeding 8 time units per lifetime)	16511-16514, 16517, 16519
– periodontal scaling (not exceeding 8 time units per year)	11112-11116,11119
– root planing	43421-43427,43429
– surgical services	42111,42201,42311,42321,42331,42339, 42341,42411,42421,42431,42441,42451, 42511,42521,42531,42541,42551,42611, 42621,42711,42811,42819
– post surgical treatment	42821-42823,42829
– post treatment evaluation	49101,49102,49109
– adjunctive procedures	43111,43221,,43231,43241,43251,43261 ,43271,43621- 43623,43631,43632,14611, 14612
– fractures and reductions	76941,76949,76951,76952,76959
(c) laboratory procedures	99111,99333

If scaling treatment is covered under both preventive and periodontic services, we will determine whether such treatment is payable under the preventive or periodontic services based on the following:

☐ Scaling treatment shall be considered preventive scaling provided the charge for such treatment is for less than 2 units of time.

☐ Scaling treatment shall be considered periodontal scaling provided the charge for such treatment is for 2 or more units of time.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement of periodontal appliances which have been lost, stolen or mislaid,
3. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Denture Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) partial and complete dentures	
– complete dentures	51101-51103,51301-51303,51601-51603
– partial dentures	52101-52103,52111-52113,52201-52203, 52211-52213,52301-52303,52311-52313, 52401-52403,52411-52413,53101-53103, 53111-53113,53121-53123,53131-53133 53201-53203,53205,53211-53213,53215, 53221-53223,53301,53302,53401-53403, 53501-53503,53611-53613,53621-53623, 54301-54303
(b) remakes and adjustments	
– adjustment to dentures	54201,54202,54209,54401-54403,54501-54503
– remake partial dentures	56411-56413
(c) denture repairs and additions	55101,55102,55201-55203,55301,55302, 55401-55403
– polishing	55501,55509
(d) relining and rebasing of dentures	56211-56213,56221-56223,56231-56233, 56241-56243,56251-56253,56261-56263, 56311-56313,56321-56323,56331-56333, 56341-56343,56511-56513,56521-56523
– miscellaneous denture services	56601,56602
(e) laboratory procedures	99111,99333

Replacement of an existing denture or bridgework with a denture, is an eligible expense if the replacement is required to replace an existing denture which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

If the existing denture is an immediate or transitional denture and replacement by a permanent denture is required, the permanent denture must be replaced within 12 months from the date of installation of the immediate or transitional denture. If the immediate or transitional denture is not replaced within 12 months of installation, such denture will be considered a permanent denture. This provision will not apply in the case of accidental injury involving a Child under age 18.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement dentures which have been lost, stolen or mislaid,
3. expenses for prosthetic devices which are ordered while the member or dependant is insured under this benefit but are installed 90 days after termination of this benefit,
4. expenses for replacement of dentures and addition of teeth to existing dentures except as provided under Eligible Expenses,
5. personalization or characterization of dentures,
6. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Bridge Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) fixed bridgework	
– bridge pontics	62101-62103,62501,62502,62701-62703, 62801
– retainers	67101,67102,67121,67129,67131,67139, 67201,67202,67211,67212,67301,67302, 67311,67312,67321,67322,67331,67341, 67501
– other prosthetic services	69101,69301-69305,69701,69702
(b) repairs and adjustments	
– repairs to bridges	66111-66113,66119,66211-66213,66219, 66301-66303,66309
– porcelain repairs	66711,66719,66721,66729,66731,66739
(c) laboratory procedures	99111,99333

Replacement of an existing denture or bridgework with bridgework is an eligible expense if the replacement is required to replace an existing denture or bridgework which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

Coverage for bridgework involving one or more permanent molars is limited to the cost of a full metal pontic or retainer.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while the member or dependant is insured under this benefit but are installed 90 days after termination of this benefit,
4. expenses for replacement of bridgework and addition of teeth to existing bridgework except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Crown Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) crowns, inlays, onlays	
– inlays and onlay restorations	25111-25114,25121-25124,25131-25134, 25141-25144,25511,25512,25521,25531
– crowns	25711-25713,25721-25724,27111-27113, 27114,27121,27122,27201,27211,27212, 27221,27301,27302,27311-27313
– other restorative services	21301,21302,21501,23601,23602,25601-25605,25731-25733,25741-25743,25751-25756,27401,27409,28102,29401
– prefabricated restorations	22201,22202,22211,22212,22301,22302, 22311,22312,22401,22411,22501,22511
– gold foil restorations	24101-24104,24201,24202
(b) repairs and adjustments	
– porcelain repairs	27711,27721,27722
– recementing crowns	29101-29103,29109,29301-29303,29309
(c) laboratory procedures	99111,99333

Replacement of an existing crown, inlay or onlay is an eligible expense if the replacement is required to replace an existing crown, inlay or onlay which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original crown, inlay or onlay.

Coverage for a crown, inlay or onlay placed on a permanent molar is limited to the cost of a full metal crown, inlay or onlay.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while the member or dependant is insured under this benefit but are installed 90 days after termination of this benefit,
4. expenses for replacement of crowns, inlays or onlays except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance - Endodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures	Canadian Dental Association Procedure Codes
(a) endodontics	
– caries, trauma control	20131,20139
– pulpotomy	32221,32222,32231,32232
– root canal therapy	33111-33114,33116,33121-33124,33126, 33131-33134,33136,33141-33144,33146, 33401-33403,33601-33605,33611-33614, 33621-33624
– apical services	34111,34112,34121-34123,34131-34134, 34141,34142,34151-34153,34161-34164, 34211,34212,34221-34224,34231-34234, 34241,34242,34251-34254,34261-34264, 34311,34312,34321-34324,34331-34334, 34341,34342,34351-34354,34361-34364 34411,34412,34421-34423,34451-34453, 34601,34602
– other endodontic procedures	39101,39201,39202,39211,39212,39411-39413
– emergency procedures	32311-32314,32321,32322
(b) laboratory procedures	99111,99333

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Summary of Insurance – Division 1

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine active union employees	$60,000

Termination of Insurance: : end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Optional Member Life Insurance

Class of Members	Benefit
Scully Mine active union employees	$60,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Optional Dependant Life Insurance

Spouse: $5,000

Each Child: $5,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Short Term Disability Insurance

Class of Members	Benefit Formula	Maximum Weekly Benefit
Scully Mine active union employees	66 2/3% of weekly earnings	the greater of $625 or E.I. maximum*

*The E.I. maximum is equal to the current percentage of the maximum insurable earnings in force under the Employment Insurance regulations at the beginning of disability.

Effective March 1, 2011, the maximum Weekly Benefit increases to $650
Effective March 1, 2013, the maximum Weekly Benefit increases to $675

Qualifying Period

- 3 consecutive calendar days of total disability, or, if shorter, the period before the first day the patient was admitted to a hospital as an in-patient and hospitalized overnight, or
- none if total disability is due to an accidental injury caused by an unforeseen event and total disability began within 30 calendar days of the initial injury.

Employees referred outside of Labrador West for medical consultation may claim short term disability benefits for any period of lost earnings exceeding the current qualifying period.

Benefit Period:

- Employees with less than one year of service – 26 weeks
- Employees with one or more years of service – 39 weeks

Termination of Insurance: termination of employment of retirement, if earlier

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
Scully Mine active union employees	60% of monthly earnings	$2,150*

*****Effective March 1, 2011, the maximum Monthly Benefit increases to $2,200
Effective March 1, 2013, the maximum Monthly Benefit increases to $2,250

Qualifying Period

If the disability is due to a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of disability and exhaustion of all payments under such Automobile Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

If the disability is not a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of Short Term Disability and exhaustion of all payments made under the Employment Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

Benefit Period

- 2 to 5 years of continuous service: the number of years and full calendar months of continuous service, but in no event later than the end of the month in which the employee attains age 65.
- 5 to 8 years of continuous service: end of month in which the employees attains age 65.
- 8 years or more of continuous service: until the earlier of retirement date or the end of the month in which the member attains age 65.

Termination of Insurance: age 65 or retirement, if earlier

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
B	Vision: $200**	none	none	100%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A, B and D. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability.
The lifetime maximum amounts are transferable between spouses.

**The maximum for eyeglasses/contact lenses every 24 month period for the member and each insured dependant.

Termination of Insurance: last day of the month of termination of employment or retirement, if earlier

Dental Insurance

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	$1,000*
B	Restorative	none	100%	$1,000*
C	Orthodontic	none	50%	$1,000**
D	Periodontic	none	80%	$1,000*
E	Denture	none	50%	$1,000*
F	Bridge	none	50%	$1,000*
G	Crown	none	50%	$1,000*
H	Endodontic	none	80%	$1,000*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for the member and for each insured dependant.

The maximum lifetime amount payable applies to the eligible expenses incurred under Part C. **The Orthodontic benefit is for insured dependent children under age 19.

Dental Insurance will be continued for members, and their eligible dependants, absent from work due to sickness, occupational accident or non-occupational accident for a maximum period of 6 months.

Termination of Insurance: termination of employment or retirement, if earlier

Dental Fee Guide: The applicable fee guide is the 2007* fee guide in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide plus an inflationary adjustment determined by us. For services provided by dental specialists, the fee guide for dental specialists will apply.

*Effective January 1, 2011, the Dental Fee Guide changes to 2008
Effective January 1, 2012, the Dental Fee Guide changes to 2009
Effective January 1, 2013, the Dental Fee Guide changes to 2010
Effective January 1, 2014, the Dental Fee Guide changes to 2011.

Summary of Insurance – Division 2

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire active union employees	$70,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Optional Member Life Insurance

Class of Members	Benefit
Pointe-Noire active union employees	$60,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Optional Dependant Life Insurance

Spouse: $5,000

Each Child: $5,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Short Term Disability Insurance

Class of Members	Benefit Formula	Maximum Weekly Benefit
Pointe-Noire active union employees	66 2/3% of weekly earnings	the greater of $625 or E.I. maximum*

*The E.I. maximum is equal to the current percentage of the maximum insurable earnings in force under the Employment Insurance regulations at the beginning of disability.

Effective March 1, 2011, the maximum Weekly Benefit increases to $650
Effective March 1, 2013, the maximum Weekly Benefit increases to $675

Qualifying Period

- 3 consecutive calendar days of total disability, or, if shorter, the period before the first day the patient was admitted to a hospital as an in-patient and hospitalized overnight, or
- none if total disability is due to an accidental injury caused by an unforeseen event and total disability began within 30 calendar days of the initial injury.

Employees referred outside of Sept-Iles for medical consultation may claim short term disability benefits for any period of lost earnings exceeding the current qualifying period.

Benefit Period:

- Employees with less than one year of service – 26 weeks
- Employees with one or more years of service – 39 weeks

Termination of Insurance: termination of employment of retirement, if earlier

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
Pointe-Noire active union employees	60% of monthly earnings	$2,150*

*****Effective March 1, 2011, the maximum Monthly Benefit increases to $2,200
Effective March 1, 2013, the maximum Monthly Benefit increases to $2,250

Qualifying Period

If the disability is due to a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of disability and exhaustion of all payments under such Automobile Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

If the disability is not a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of Short Term Disability and exhaustion of all payments made under the Employment Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

Benefit Period

- 2 to 5 years of continuous service: the number of years and full calendar months of continuous service, but in no event later than the end of the month in which the employee attains age 65.
- 5 to 8 years of continuous service: end of month in which the employees attains age 65.
- 8 years or more of continuous service: until the earlier of retirement date or the end of the month in which the member attains age 65.

Termination of Insurance: age 65 or retirement, if earlier

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
B	Vision: $200**	none	none	100%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A, B and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

**The maximum for eyeglasses/contact lenses every 24 month period for the member and each insured dependant.

Termination of Insurance: last day of the month of termination of employment or retirement, if earlier

Drug coverage for Québec residents

For all members under age 65 and members age 65 and over who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, the member's out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Lifetime/Annual Maximum: The combined lifetime/annual maximum does not apply to the Drug Benefit.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Dental Insurance

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	$1,000*
B	Restorative	none	100%	$1,000*
C	Orthodontic	none	50%	$1,000**
D	Periodontic	none	80%	$1,000*
E	Denture	none	50%	$1,000*
F	Bridge	none	50%	$1,000*
G	Crown	none	50%	$1,000*
H	Endodontic	none	80%	$1,000*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for the member and for each insured dependant.

The maximum lifetime amount payable applies to the eligible expenses incurred under Part C. **The Orthodontic benefit is for insured dependent children under age 19.

Dental Insurance will be continued for members, and their eligible dependants, absent from work due to sickness, occupational accident or non-occupational accident for a maximum period of 6 months.

Termination of Insurance: termination of employment or retirement, if earlier

Dental Fee Guide: The applicable fee guide is the fee guide in effect 3 years* before the prevailing fee guide in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, the prevailing fee guide is the 1997 Alberta Fee Guide plus an annual inflationary adjustment determined by us. The fee guide will be updated

*Effective January 1, 2015, the Dental Fee Guide changes to 2012
Effective January 1, 2016, the Dental Fee Guide changes to 2013
Effective January 1, 2017, the Dental Fee Guide changes to 2014
Effective January 1, 2018, the Dental Fee Guide changes to 2015
Effective January 1, 2019, the Dental Fee Guide changes to 2016
Effective January 1, 2020, the Dental Fee Guide changes to 2017.

Summary of Insurance – Division 4

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire active union employees 65 years of age or more	$70,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Optional Member Life Insurance

Class of Members	Benefit
Pointe-Noire active union employees 65 years of age or more	$60,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Optional Dependant Life Insurance

Spouse: $5,000

Each Child: $5,000

Termination of Insurance: end of the month following termination of employment, retirement or end of the month if the member does not make the required contributions, if earlier

Short Term Disability Insurance

Class of Members	Benefit Formula	Maximum Weekly Benefit
Pointe-Noire active union employees 65 years of age or more	66 2/3% of weekly earnings	the greater of $625 or E.I. maximum*

*The E.I. maximum is equal to the current percentage of the maximum insurable earnings in force under the Employment Insurance regulations at the beginning of disability.

Effective March 1, 2011, the maximum Weekly Benefit increases to $650
Effective March 1, 2013, the maximum Weekly Benefit increases to $675

Qualifying Period

- 3 consecutive calendar days of total disability, or, if shorter, the period before the first day the patient was admitted to a hospital as an in-patient and hospitalized overnight, or

  none if total disability is due to an accidental injury caused by an unforeseen event and total disability began within 30 calendar days of the initial injury

Employees referred outside of Sept-Iles for medical consultation may claim short term disability benefits for any period of lost earnings exceeding the current qualifying period.

Benefit Period:

- Employees with less than one year of service – 26 weeks
- Employees with one or more years of service – 39 weeks

Termination of Insurance: termination of employment of retirement, if earlier

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
B	Vision: $200**	none	none	100%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A, B and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

**The maximum for eyeglasses/contact lenses every 24 month period for the member and each insured dependant.

Termination of Insurance: last day of the month of termination of employment or retirement, if earlier

Drug coverage for Québec residents

For all members age 65 and over who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)
In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, the member's out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Lifetime/Annual Maximum: The combined lifetime/annual maximum does not apply to the Drug Benefit.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Dental Insurance

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	$1,000*
B	Restorative	none	100%	$1,000*
C	Orthodontic	none	50%	$1,000**
D	Periodontic	none	80%	$1,000*
E	Denture	none	50%	$1,000*
F	Bridge	none	50%	$1,000*
G	Crown	none	50%	$1,000*
H	Endodontic	none	80%	$1,000*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for the member and for each insured dependant.

The maximum lifetime amount payable applies to the eligible expenses incurred under Part C. **The Orthodontic benefit is for insured dependent children under age 19.

Dental Insurance will be continued for members, and their eligible dependants, absent from work due to sickness, occupational accident or non-occupational accident for a maximum period of 6 months.

Termination of Insurance: termination of employment or retirement, if earlier

Dental Fee Guide: The applicable fee guide is the fee guide in effect 3 years* before the prevailing fee guide in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, the prevailing fee guide is the 1997 Alberta Fee Guide plus an annual inflationary adjustment determined by us. The fee guide will be updated

*Effective January 1, 2015, the Dental Fee Guide changes to 2012
Effective January 1, 2016, the Dental Fee Guide changes to 2013
Effective January 1, 2017, the Dental Fee Guide changes to 2014
Effective January 1, 2018, the Dental Fee Guide changes to 2015
Effective January 1, 2019, the Dental Fee Guide changes to 2016
Effective January 1, 2020, the Dental Fee Guide changes to 2017.

Summary of Insurance – Division 5

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire retirees of pre-March 1999 who were under age 62 at retirement, who are currently age 65 and over and surviving spouse of retirees age 65 and over at the time of death	See Appendix

Termination of Insurance: none

Extended Health Insurance (Real Coordination of Drug Benefits with RAMQ)

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug	none	none	90%*	$5,000**/40,000***

*For any drugs payable in part by the RAMQ for persons age 65 and over covered by the RAMQ drug insurance plan, coverage is adjusted so that the drug expenses actually paid for by this plan and the RAMQ plan do not exceed the amount that would have been covered if the member had participated in this plan only.

**The maximum applies per calendar year for the member and each insured dependant. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the annual maximum. Once the annual maximum has been reached, all RAMQ drugs continue to be paid.

***The maximum applies per lifetime for the member and each insured dependant. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: none

Summary of Insurance – Division 6

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire retirees currently age 65 or over who retired before March 1999 and who were age 62 or over at retirement	See Appendix

Termination of Insurance: none

Extended Health Insurance (Real Coordination of Drug Benefits with RAMQ)

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug	none	none	90*	$5,000***/$40,000****
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	$30**	$45**	90%	$5,000***/$40,000****
E	Out-of-Province Emergency	none	none	100%	--

*For any drugs payable in part by the RAMQ for persons age 65 and over covered by the RAMQ drug insurance plan, coverage is adjusted so that the drug expenses actually paid for by this plan and the RAMQ plan do not exceed the amount that would have been covered if the member had participated in this plan only.

**The deductible applies per calendar year. If the member and one or more of his dependants, or if two or more of his dependants incur eligible expenses as a result of the same accident, only one deductible amount will be applied during the calendar year in which the accident occurs against the eligible expenses due to such accident for all individuals.

***The maximum applies per calendar year for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the annual maximum. Once the annual maximum has been reached, all RAMQ drugs continue to be paid.

****The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: none

Summary of Insurance – Division 15

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine retirees of pre-March 1999 who were under 62 at retirement and surviving spouses of retirees	See Appendix

Termination of Insurance: none

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$5,000*/$40,000**

*The maximum applies per calendar year for the member and insured spouse.

**The maximum applies per lifetime for the member and insured spouse. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured spouse, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: none

Summary of Insurance – Division 16

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine retirees on or after March 1, 1999 but prior to October 12, 2004	See Appendix

Termination of Insurance: none

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$40,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$40,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: none

Summary of Insurance – Division 17

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine retirees of pre-March 1999 who were age 62 or over at retirement and surviving spouse of active employees who died prior to October 12, 2004	See Appendix

Termination of Insurance: none

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$5,000*/$40,000**
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$5,000*/$40,000**
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per calendar year for the member and insured spouse. The maximum applies to the combined eligible expenses of Parts A and D.

**The maximum applies per lifetime for the member and insured spouse. The maximum applies to the combined eligible expenses of Parts A and D. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured spouse, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Members age 65 and over who are covered by the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

- ·The coinsurance amount and the deductible that the member must pay under their RAMQ plan are eligible and will be reimbursed at the reimbursement level of this plan.

Termination of Insurance: none

Summary of Insurance – Division 18

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine employees who became disabled prior to March 1, 1999	See Appendix

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Optional Member Life Insurance

Class of Members	Benefit
Scully Mine employees who became disabled prior to March 1, 1999	$50,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Optional Dependant Life Insurance

Spouse: $5,000

Each Child: $5,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Long Term Disability Insurance

Class of Members	Benefit
Scully Mine employees who became disabled prior to March 1, 1999	See Appendix

Qualifying Period

If the disability is due to a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of disability and exhaustion of all payments under such Automobile Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

If the disability is not a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of Short Term Disability and exhaustion of all payments made under the Employment Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

Benefit Period

- 2 to 5 years of continuous service: the number of years and full calendar months of continuous service, but in no event later than the end of the month in which the employee attains age 65
- 5 to 8 years of continuous service: end of month in which the employees attains age 65
- 8 years or more of continuous service: until the earlier of 30 years of continuous service, normal retirement date or the end of the month in which the member attains age 65.

Termination of Insurance: age 65, 30 years of service or retirement, if earlier

Extended Health Insurance

Extended Health Insurance is continued at the policyholder's expense during the 2 year period from the end of the month in which the disability occurred. Thereafter, for those employees eligible and approved to receive Long Term Disability benefits, these coverage are continued until the end of the month in which such Long Term Disability benefit ceases.

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$5,000*/$40,000**
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$5,000*/$40,000**
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per calendar year for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D.

**The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance:

- 2 years from the end of the month in which disability occurred if an employee is not entitled to receive Long Term Disability payments
- end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act
- last day of the month of termination of employment
- retirement

whichever is earlier.

Dental Insurance

Dental Insurance will be continued for all Long Term Disability claimants whose disability started after March 1st, 1996 and their eligible dependants.

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	$400*
B	Restorative	none	100%	$400*
C	Orthodontic	none	50%	$400**
D	Periodontic	none	80%	$400*
E	Denture	none	50%	$400*
F	Bridge	none	50%	$400*
G	Crown	none	50%	$400*
H	Endodontic	none	80%	$400*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for the member and for each insured dependant.

The maximum lifetime amount payable applies to the eligible expenses incurred under Part C. **The Orthodontic benefit is for insured dependent children under age 19.

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Dental Fee Guide: The applicable fee guide is the 1999 fee guide in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide plus an inflationary adjustment determined by us.

Summary of Insurance – Division 20

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine employees who became disabled on or after October 12, 2004 and who are entitled to Long Term Disability benefits	$60,000
Scully Mine employees who became disabled on or after October 12, 2004 and who are not entitled to Long Term Disability benefits	$60,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Optional Member Life Insurance

Class of Members	Benefit
Scully Mine employees who became disabled on or after October 12, 2004 and who are entitled to Long Term Disability benefits	$60,000
Scully Mine employees who became disabled on or after October 12, 2004 and who are not entitled to Long Term Disability benefits	$60,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Optional Dependant Life Insurance

Spouse: $5,000

Each Child: $5,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
Scully Mine employees who became disabled on or after October 12, 2004 and who are entitled to Long Term Disability benefits	60% of monthly earnings	$2,100

Qualifying Period

If the disability is due to a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of disability and exhaustion of all payments under such Automobile Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

If the disability is not a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of Short Term Disability and exhaustion of all payments made under the Employment Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

Benefit Period

- 2 to 5 years of continuous service: the number of years and full calendar months of continuous service, but in no event later than the end of the month in which the employee attains age 65
- 5 to 8 years of continuous service: end of month in which the employees attains age 65
- 8 years or more of continuous service: until the earlier of 30 years of continuous service, normal retirement date or the end of the month in which the member attains age 65. However, Long Term Disability benefits may continue for up to 12 months beyond the later of a Long Term Disability claimant's 30 year anniversary or of his Long Term Disability eligibility date, provided the member has the potential to return to work at the end of the 12 month period in question. The employee's attending physician must certify that in his opinion the employee's health will allow the disabled employee to return to work after said additional 12 month period, at the latest, and the employee clearly indicates his desire to return to work after said additional 12 month period at the latest

Termination of Insurance: age 65, 30 years of service or retirement, if earlier

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
B	Vision: $200**	none	none	100%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A, B and D. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability.
The lifetime maximum amounts are transferable between spouses.

**The maximum for eyeglasses/contact lenses every 24 month period for the member and each insured dependant.

Termination of Insurance:

- 2 years from the end of the month in which disability occurred if an employee is not entitled to receive Long Term Disability payments
- end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act
- last day of the month of termination of employment

- retirement

whichever is earlier.

Dental Insurance (Class 20)

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	$400*
B	Restorative	none	100%	$400*
C	Orthodontic	none	50%	$400**
D	Periodontic	none	80%	$400*
E	Denture	none	50%	$400*
F	Bridge	none	50%	$400*
G	Crown	none	50%	$400*
H	Endodontic	none	80%	$400*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for the member and for each insured dependant.

The maximum lifetime amount payable applies to the eligible expenses incurred under Part C. **The Orthodontic benefit is for insured dependent children under age 19.

Termination of Insurance: termination of employment or retirement, if earlier

Dental Fee Guide: The applicable fee guide is the 2005 fee guide in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide plus an inflationary adjustment determined by us.

Summary of Insurance – Division 25

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire retirees of pre-March 1999 who were under age 62 and currently under age 65 and surviving spouse of retirees under age 65 at the time of death	See Appendix

Termination of Insurance: age 65

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug	$30*	$45*	90%	$5,000**/$40,000***

*The deductible applies per calendar year. If the member and one or more of his dependants, or if two or more of his dependants incur eligible expenses as a result of the same accident, only one deductible amount will be applied during the calendar year in which the accident occurs against the eligible expenses due to such accident for all individuals.

**The maximum applies per calendar year for the member and each insured dependant. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the annual maximum. Once the annual maximum has been reached, all RAMQ drugs continue to be paid.

***The maximum applies per lifetime for the member and each insured dependant. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: age 65

Drug coverage for Québec residents

For all members under age 65 who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, the member's out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Lifetime/Annual Maximum: The combined lifetime/annual maximum does not apply to the Drug Benefit.

Deductible: The deductible is applied up to the annual out-of-pocket maximum and will not apply after the annual maximum has been reached.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Summary of Insurance – Division 26

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire retirees on or after March 1, 1999 but prior to October 12, 2004 and surviving spouse of active employees who died prior to October 12, 2004	See Appendix

Termination of Insurance: none

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%*	$40,000**
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$40,000**
E	Out-of-Province Emergency	none	none	100%	--

*For any drugs payable in part by the RAMQ for persons age 65 and over covered by the RAMQ drug insurance plan, coverage is adjusted so that the drug expenses actually paid for by this plan and the RAMQ plan do not exceed the amount that would have been covered if the member had participated in this plan only.

Drug coverage for Québec residents

For all members under age 65 who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, the member's out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

******The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $40,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Termination of Insurance: none

Summary of Insurance – Division 27

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire employees who became disabled on or after October 12, 2004 and who are entitled to Long Term Disability benefits	$60,000
Pointe-Noire employees who became disabled on or after October 12, 2004 and who are not entitled to Long Term Disability benefits	$60,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Optional Member Life Insurance

Class of Members	Benefit
Pointe-Noire employees who became disabled after October 11, 2004 and who are entitled to Long Term Disability benefits	$60,000
Pointe-Noire employees who became disabled after October 11, 2004 and who are not entitled to Long Term Disability benefits	$60,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Optional Dependant Life Insurance

Spouse: $5,000

Each Child: $5,000

Termination of Insurance: end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act.

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
Pointe-Noire employees who became disabled after October 11, 2004 and who are entitled to Long Term Disability benefits	60% of monthly earnings	$2,100

Qualifying Period

If the disability is due to a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of disability and exhaustion of all payments under such Automobile Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

If the disability is not a compensable disability under an Automobile Insurance Act, benefits will be payable after 39 weeks of Short Term Disability and exhaustion of all payments made under the Employment Insurance Act and any annual and accrued vacation and vacation extension which must be taken by the member or optional time entitlement under the policyholder's continuous service bonus plan.

Benefit Period

- 2 to 5 years of continuous service: the number of years and full calendar months of continuous service, but in no event later than the end of the month in which the employee attains age 65
- 5 to 8 years of continuous service: end of month in which the employees attains age 65
- 8 years or more of continuous service: until the earlier of 30 years of continuous service, normal retirement date or the end of the month in which the member attains age 65. However, Long Term Disability benefits may continue for up to 12 months beyond the later of a Long Term Disability claimant's 30 year anniversary or of his Long Term Disability eligibility date, provided the member has the potential to return to work at the end of the 12 month period in question. The employee's attending physician must certify that in his opinion the employee's health will allow the disabled employee to return to work after said additional 12 month period, at the latest, and the employee clearly indicates his desire to return to work after said additional 12 month period at the latest

Termination of Insurance: age 65, 30 years of service or retirement, if earlier

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
B	Vision: $200**	none	none	100%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A, B and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

**The maximum for eyeglasses/contact lenses every 24 month period for the member and each insured dependant.

Termination of Insurance:

- 2 years from the end of the month in which disability occurred if an employee is not entitled to receive Long Term Disability payments
- end of the month in which the member last draws a payment from S&A, LTD, Worker's Compensation or Automobile Insurance Act

- last day of the month of termination of employment
- retirement

whichever is earlier.

Drug coverage for Québec residents

For all members under age 65 and members age 65 and over who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, the member's out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Lifetime/Annual Maximum: The combined lifetime/annual maximum does not apply to the Drug Benefit.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Dental Insurance (Class 27)

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	$400*
B	Restorative	none	100%	$400*
C	Orthodontic	none	50%	$400**
D	Periodontic	none	80%	$400*
E	Denture	none	50%	$400*
F	Bridge	none	50%	$400*
G	Crown	none	50%	$400*
H	Endodontic	none	80%	$400*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D, E, F, G and H for the member and for each insured dependant.

The maximum lifetime amount payable applies to the eligible expenses incurred under Part C. **The Orthodontic benefit is for insured dependent children under age 19.

Termination of Insurance: termination of employment or retirement, if earlier

Dental Fee Guide: Dental Fee Guide: The applicable fee guide is the 2005 fee guide in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide plus an inflationary adjustment determined by us.

Summary of Insurance – Division 30

Basic Member Life Insurance

Class of Members	Benefit
Scully Mine employees who retired on or after October 11, 2004 and surviving spouse of active employees who died after October 11, 2004	$12,500*

*For employees who, on or after October 8, 2004, retire on Special Early Retirement or on Early Retirement at age 62 or over, with 10 or more years of service, the Basic Life Insurance in effect prior to their retirement shall be maintained until age 65 at which time it reduces to $12,500

Termination of Insurance: none

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability.
The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: none

Summary of Insurance – Division 40

Basic Member Life Insurance

Class of Members	Benefit
Pointe-Noire employees who retired on or after October 12, 2004	$12,500*

*For employees who, on or after October 8, 2004, retire on Special Early Retirement or on Early Retirement at age 62 or over, with 10 or more years of service, the Basic Life Insurance in effect prior to their retirement shall be maintained until age 65 at which time it reduces to $12,500

Termination of Insurance: none

Extended Health Insurance

Part	Benefit	Deductible		Reimburse-ment	Maximum
		per person	per family unit		
A	Drug: Pay Direct	none	none	85%	$60,000*
C	Hospital: ward to semi-private	none	none	100%	--
C1	Ambulance Services	none	none	100%	--
D	Supp. Health Care	none	none	85%	$60,000*
E	Out-of-Province Emergency	none	none	100%	--

*The maximum applies per lifetime for the member and each insured dependant. The maximum applies to the combined eligible expenses of Parts A and D. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a member or an insured dependant, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability. The lifetime maximum amounts are transferable between spouses.

Termination of Insurance: none

Drug coverage for Québec residents

For all members under age 65 and members age 65 and over who are not covered by the Québec Drug Insurance Plan of the Régie de l'assurance-maladie du Québec (RAMQ)

In addition to the above provisions, the following applies to the Drug Benefit for Québec residents who purchase an eligible drug that is included on the Régie de l'assurance-maladie du Québec (RAMQ) formulary:

Annual Out-of-Pocket Maximum: The maximum for out-of-pocket eligible expenses is limited to the amount specified by law and applied in the provincial drug plan administered by the RAMQ. The annual out-of-pocket maximum amount applies separately to each adult under the plan. However, the member's out-of-pocket maximum includes expenses for each dependent child.

Out-of-pocket eligible expenses include any deductible and co-payment.

Lifetime/Annual Maximum: The combined lifetime/annual maximum does not apply to the Drug Benefit.

Reimbursement: The reimbursement percentage is applied up to the annual out-of-pocket maximum. After the annual maximum is reached, eligible expenses will be reimbursed at 100%. The reimbursement percentage applies after any deductibles have been satisfied.

Summary of Insurance – Division 105

Extended Health Insurance (Real Coordination of Drug Benefits with RAMQ)

Part	Benefit	Deductible per person	Reimbursement	Maximum
A	Drug: Pay Direct	none	85%*	$60,000**

* For any drugs payable in part by the RAMQ for persons age 65 and over covered by the RAMQ drug insurance plan, coverage is adjusted so that the drug expenses actually paid for by this plan and the RAMQ plan do not exceed the amount that would have been covered if the surviving spouse had participated in this plan only.

**The maximum applies per lifetime for the surviving spouse. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a surviving spouse and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability.

Termination of Insurance: none

Summary of Insurance – Division 115

Extended Health Insurance

Part	Benefit	Deductible per person	Reimbursement	Maximum
A	Drug: Pay Direct	none	85%	$60,000*

*The maximum applies per lifetime for insured surviving spouse. If at any time benefits of at least $1,000 have been paid for eligible expenses of the insured surviving spouse, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability.

Termination of Insurance: none

Summary of Insurance – Division 125

Extended Health Insurance

Part	Benefit	Deductible per person	Reimbursement	Maximum
A	Drug: Pay Direct	none	85%	$60,000*

*The maximum applies per lifetime for the surviving spouse. All drugs (RAMQ and non-RAMQ drugs) contribute to the accumulation of the lifetime maximum. Once the lifetime maximum has been reached, all RAMQ drugs continue to be paid. If at any time benefits of at least $1,000 have been paid for eligible expenses of a surviving spouse, and evidence of the complete recovery and insurability of the person on whose account such benefits are paid is submitted to Sun Life, the amount of such benefits paid will not be included in determining the $60,000 maximum amount of benefits on account of such person on and after the date Sun Life accepts as satisfactory such evidence of insurability.

Termination of Insurance: age 65