Contract Number: 103173, 153173 and BSC 9142124
Effective: January 1, 2020
Issued: April 21, 2020

your group benefits

Canadian Pacific Railway Company

Active Employees - TCRC-RTE Hired on or after July 20, 2018

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Sun Life Financial

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How to Connect with Sun Life Financial

Questions?

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

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

Plan Member Services

Download the my Sun Life Mobile App!

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

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

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

Access to mysunlife website

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

Your Travel Card

Provided online at www.mysunlife.ca.

Need to contact Allianz Global Assistance?

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

All other inquiries

Call 1-866-881-0583.

Benefit Summary

The information contained in this summary applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Employee and Family Assistance Program, Weekly Indemnity and Basic Accidental Death and Dismemberment benefits described later in this booklet are not insured or administered by Sun Life.

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

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Waiting period	The waiting period is: • For Life coverage, the period ending on the last day of the month in which your employment began. However, if your employment began on the first day of the month, there is no waiting period • none for all other benefits Any period during which you do not meet the eligibility requirements cannot be counted as part of the waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care - Contract Number 153173

Benefit year	January 1 to December 31
Deductible	None
Reimbursement level	
Prescription drugs	80% Lifetime maximum of $200,000 per person For employees residing in Québec, the reimbursement percentage is increased to 100% once the out-of-pocket maximum has been reached Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation* We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist: • drugs that legally require a prescription • life-sustaining drugs that may not legally require a prescription

	• intrauterine devices (IUDs) and diaphragms • products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $400 per person There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.
Québec drug insurance plan	Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements
In-province hospital	100% of the difference between the cost of a ward and a semi-private room
Convalescent hospital	100% of the difference between the cost of a ward and a semi-private room, up to $20 per day for a maximum of 120 days for treatment of an illness due to the same or related causes
Out-of-province emergency services	100% Emergency Travel Assistance included Time limit – 180 days after the date the person leaves the province where the person lives Lifetime maximum of $5,000,000 per person for out-of-Canada services
Out-of-province referred services	100%
Medical services and equipment	100%
Paramedical services	100%, up to a combined maximum of $1,000 per person per benefit year for qualified psychologists or social workers 100% for the qualified physiotherapists 100% up up to maximum of $500 per person per benefit year for the qualified paramedical practitioners listed below: • massage therapists • chiropractors, including x-ray examination 100% up up to maximum of $500 per person per specialty, to a combined maximum of $1,500 per person per benefit year for all the qualified paramedical practitioners listed below: • speech therapists • naturopaths • acupuncturists • osteopaths or osteopathic practitioners, including x-ray examinations • podiatrists or chiropodists, including x-ray examinations • personal support workers or Victoria order of Nurses (VON)
Vision care	Contact lenses, eyeglasses or laser eye correction surgery – 80% Services of an ophthalmologist or licensed optometrist – 80%, one examination per person in any 12 month period for a person under age 18 or in any 24 month period for any other person For all eligible expenses combined, the maximum is $325 in any 12 month period for a person under age 18 or in any 24 month period for any other person
Maximum benefit	Unlimited
Termination	When you retire

Dental Care - Contract Number 153173

Benefit year	January 1 to December 31
Deductible	None
Fee guide	The 2020 fee guide for general practitioners in the province where the treatment is received If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that specialty, then the fee guide approved by the provincial Dental Association for that specialist will be used
Reimbursement level	
Preventive procedures	100%
Basic procedures	100%
Major procedures	50%
Orthodontic procedures	80%
Maximum benefit	
Benefit year maximum	$2,050 per person If your coverage starts on or after July 1 of a benefit year, the maximum amount for that benefit year will be reduced by 50% A separate lifetime maximum (below) applies to Orthodontic expenses
Lifetime maximum	Orthodontic procedures – $1,500 per person
Termination	When you retire

Life - Contract Number 103173

Employee Basic Life

Amount	$54,000
Reduction	Coverage is reduced to $7,000 on the date you become eligible for a waiver of premium
Termination	When you retire

Employee Optional Life

Amount	You can choose coverage in units of $10,000 Maximum – $250,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire

Spouse Optional Life

Amount	You can choose coverage in units of $10,000 Maximum – $150,000
Proof of good health	Approval required on the initial optional amount of coverage and any increase in that coverage requested by the employee
Termination	When you retire

Making Claims

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator.

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

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

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

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

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

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

Type of claim	Starting the claims process	Limits and special instructions
Dental Care	Ask Sun Life for the form to complete, or get the form on our website. The dentist will have to complete a section of the form. You can also submit claims for some expenses electronically. For more information, ask Sun Life.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Dental Care coverage. If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information. For orthodontic procedures, a treatment plan will need to be submitted to us.
Life coverage	Ask Sun Life to provide the claim forms.	**If the claim is a result of a death:** We must receive the claim form within 365 days after the death occurred. **For coverage during total disability:** We must receive the proof of total disability within 180 days of the date the disability begins. After that, we can require that you provide us with ongoing proof that you are still totally disabled.

General Information

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator. The Employee and Family Assistance Program, Weekly Indemnity and Basic Accidental Death and Dismemberment benefits described later in this booklet are not insured or administered by Sun Life.

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

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

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

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

Your group benefits	The contract holder, Canadian Pacific Railway Company, self-insures the following benefits under contract number 153173: • Extended Health Care • Emergency Travel Assistance • Dental Care This means Canadian Pacific Railway Company is wholly responsible for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life under contract number 103173.
Who is eligible to receive benefits?	To be eligible for group benefits, you must reside in Canada and meet all the following conditions: • you are a permanent employee working in Canada. • you are actively working as determined by your employer. • you have completed the waiting period indicated in the Benefit Summary. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent. You must apply for coverage for yourself in order for your dependents to be eligible.
Who qualifies as your dependent	Your dependent must be: • your spouse or your child, and • residing in Canada or the United States.

Your spouse qualifies as your dependent if they are your spouse in one of the following ways:

- by marriage.
- under any other formal union recognized by law.
- as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least:
  - 1 year, if both the parties are free to marry.
  - 3 years, if either party is not free to marry.

For employees residing in Québec, there is no minimum cohabitation period if a child is born out of the relationship.
You can only cover one spouse at a time.

Your spouse no longer qualifies as your spouse on the earlier of the following dates

- the date the marriage is dissolved through divorce or annulment.
- the date the formal union recognized by law is dissolved.
- 3 months following the date of a separation.

Your children and your spouse's children (including adopted or step-children, but excluding foster children) are eligible dependents if they are under age 21 and do not have a spouse.

A child who is a full-time student under age 25 (age 26 for drugs listed in the Régie de l'assurance-maladie du Québec drug formulary for employees residing in Québec) is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse.

If a child becomes disabled before the maximum age and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse.

In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask Sun Life for more on this.**

How to enrol

For you – You must provide the proper enrolment information to Sun Life.
For a dependent – You must ask for dependent coverage.

You will need to provide proof of good health for the benefits listed below, as outlined in the Benefit Summary section at the beginning of this booklet. This coverage will not start before Sun Life has approved this proof of good health.

- Employee Optional Life
- Spouse Optional Life

When coverage begins

Your coverage begins on the date you become eligible for coverage.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

A dependent's coverage begins **on the later of** the following dates:

- the date your coverage begins.
- the date you first have a dependent.

If you are not actively working on the date your spouse's Optional Life coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

Changes affecting your coverage	If proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health. If you are not actively working when an increase in coverage occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to Sun Life: • change of dependents. • change of beneficiary. You will need to report any name change to your employer.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract, number 103173. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-866-881-0583.
When coverage ends	As an employee, your coverage will end on the earlier of the following dates: • the date your employment ends or you retire, except as stated under Continuation of coverage. • the date you are no longer actively working, except as stated under Continuation of coverage. • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends. A dependent's coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage. The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.
Continuation of coverage	When coverage would terminate because your employment ends or because you are no longer actively working, your employer may continue your coverage in the following circumstances: • during a statutory leave, as set out in applicable employment standards legislation, but not more than the period required under such legislation. • during the notice period for termination of employment as required by relevant legislation. • for a pre-determined period during you are temporarily laid off or granted a leave of absence, excluding a statutory leave or an absence due to illness, but not more than 12 months.

Also, when your coverage would terminate because you are no longer actively working due to Illness, your employer is entitled to may continue your coverage under this contract during the period you are absent from work, provided that your employment continues.

If you die while covered by this plan

Coverage for your dependents will continue until **the earlier of** the following dates:

- last day of the month following the month in which you die. However, if you die while on the job, coverage for your dependents will continue until the last day of the 3rd month following the month in which you die.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

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

The continuation of coverage does not apply to the spouse's Optional Life.

Legal actions for insured benefits

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your continued total disability. If you do not provide this information within 90 days of the request, you may not be entitled to some or all benefit payments.

Coordinating your benefits with another plan

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

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

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

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

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

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

When you send us a claim, you must tell us about all other equivalent coverage that you or your dependents have. If both you and your spouse are employed by Canadian Pacific Railway Company, we will coordinate benefits for you and your dependents under the employer's plan.

Medical examination

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

Recovering overpayments

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

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

Assignments

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

Definitions

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

Accident	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Illness	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

Extended Health Care

Plan administrator

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

General description of the coverage

The contract holder is wholly responsible for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the employee and all dependents covered for Extended Health Care benefits.

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

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed.

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

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

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

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level and maximum benefit	Claims will be paid up to the reimbursement level and maximum benefit under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary. The maximum benefit for all expenses combined is also indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 3 month period.

What is not covered	We will not pay for the following, even when prescribed: • the cost of giving injections, serums and vaccines. • treatments for weight loss, including drugs, proteins and food or dietary supplements. • hair growth stimulants. • drugs for the treatment of infertility. • drugs for the treatment of sexual dysfunction. • drugs that are used for cosmetic purposes. • natural health products, whether or not they have a Natural Product Number (NPN). • drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
Drug evaluation	The following drugs will be evaluated and must be approved by us to be eligible for coverage: • drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017. • drugs covered under this plan and subject to a significant increase in cost. Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval. We will assess the eligibility of the drug based on factors such as: • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • availability of other drugs treating the same or similar condition(s). • plan sustainability.
Pharmaceutical services (rendered by pharmacists)	For employees residing in Québec, we will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.
Out-of-pocket maximum	For employees residing in Québec, expenses incurred for prescription drugs and not reimbursed under this plan as a result of the application of the deductible or the reimbursement percentage are limited in each benefit year to the yearly maximum contribution set by the Régie de l'assurance-maladie du Québec (RAMQ). There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the parent with the greater amount of expenses during the benefit year.
Persons age 65 or over residing in Québec	Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the public prescription drug insurance plan of the Régie de l'assurance-maladie du Québec (RAMQ), which provides basic coverage for prescription drug costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be covered by either the public plan or your group plan. If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium.

	On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact us to clarify your situation.

Hospital expenses in your province

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

Expenses out of your province

Expenses out of your province	We will cover emergency services while you are outside the province where you live. We will also cover referred services. **For both emergency services and referred services, the reimbursement level is indicated in the Benefit Summary.** For both emergency services and referred services, we will cover the cost of: • a semi-private hospital room • other hospital services provided outside of Canada • out-patient services in a hospital • the services of a doctor
Emergency services	We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged. *Emergency services* mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established treatment program that existed before they left their home province.

	Emergency means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. **Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*) right away. Allianz Global Assistance must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them. **If Allianz Global Assistance does not hear from you first, before** you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency. In extreme circumstances where contact with Allianz Global Assistance cannot be made before services are provided, you must contact Allianz Global Assistance as soon as possible afterwards. An emergency ends when Allianz Global Assistance, based on available medical evidence, deems you medically stable to return to the province where you live.
Emergency services excluded from coverage	Any expenses related to the following emergency services are not covered: • services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services. • services relating to an illness or injury which caused the emergency, after such emergency ends. • continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Allianz Global Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return. • services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services. • where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.
Referred services	*Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. Your provincial medicare plan must agree in writing to pay benefits for the referred services. All referred services must be obtained in Canada, if available, regardless of any waiting lists. However, if referred services are not available in Canada, they may be obtained outside of Canada.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private duty nurse	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties	$25,000 per person per benefit year
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency services*	

Covered expenses	Details	Payment limits
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor • ultrasounds • medical imaging services, including MRIs and CT scans	
Dental services following an accident	Dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered You must receive these services within 6 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the employee lives
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs	For wheelchairs, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair For hospital beds, eligible expenses are limited to the cost of a manual hospital bed.
Casts, trusses or crutches		
Splints or braces	Must be prescribed by a doctor	
Breast prostheses or surgical brassieres	Required as a result of surgery	Combined maximum of $200 per person per benefit year
Artificial limbs and eyes		
Stump socks		5 pairs per person per benefit year
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	$50 per person per benefit year
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair per person per benefit year
Custom-made or prefabricated orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair per person per benefit year
Hearing aids		$1,000 per person over 5 benefit years Repairs and replacement batteries are included in this maximum
Oxygen		

Covered expenses	Details	Payment limits
Continuous Glucose Monitor (CGM) receivers, transmitters or sensors	Only for persons diagnosed with Type 1 diabetes You must provide us with a doctor's note confirming the diagnosis	Combined maximum of $4,000 per person per benefit year
Colostomy supplies		
Incontinence supplies such as diapers, pads and disposable briefs	Required as a result of an illness	
Dressings, excluding bandages	Must be medicated dressings	
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary
Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us. *Qualified* paramedical practitioners must: • belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us, • be licensed or registered, as required by the applicable provincial regulatory body, • have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered, • maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association, • produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and • not engage in administrative practices unacceptable to us. This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.		
Vision care		
Contact lenses, eyeglasses or laser eye correction surgery and services of an ophthalmologist or licensed optometrist	An ophthalmologist or licensed optometrist must have prescribed contact lenses or eyeglasses You must have received the above from an ophthalmologist, licensed optometrist or optician We will only cover laser eye correction surgery that an ophthalmologist has performed	Up to the reimbursement level indicated in the Benefit Summary We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision

When coverage ends

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that we consider ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

We will not pay benefits when the claim is for an illness resulting from:

- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

Integrating this plan with government programs

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

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

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

Emergency Travel Assistance

Plan administrator

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

General description of the coverage

The contract holder is wholly responsible for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the employee and all dependents covered for Emergency Travel Assistance benefits.

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

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

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

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

Getting help	**Contact us right away in an emergency!** You or someone with you must contact AZGA Service Canada Inc. (*Allianz Global Assistance*) right away.
	If Allianz Global Assistance does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Allianz Global Assistance cannot be made before services are provided, you must contact Allianz Global Assistance as soon as possible afterwards. Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card.

	Allianz Global Assistance may arrange for:
On the spot medical assistance	Allianz Global Assistance will provide referrals to physicians, pharmacists and medical facilities. As soon as Allianz Global Assistance is notified that you have a medical emergency, its staff, or a physician designated by Allianz Global Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Allianz Global Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service. Allianz Global Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel. Allianz Global Assistance will transmit an urgent message from you to your home, business or other location. Allianz Global Assistance will keep messages to be picked up in its offices for up to 15 days.
Transportation home or to a different medical facility	Allianz Global Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Allianz Global Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation. Sun Life or Allianz Global Assistance, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.
Meals and accommodations expenses	If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Allianz Global Assistance will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days. Allianz Global Assistance will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Allianz Global Assistance, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.
Travel expenses home if stranded	Allianz Global Assistance will arrange and, if necessary, advance funds for transportation to the province where you live: • for you if, due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated (sent home); or • **for a** child if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Allianz Global Assistance will also make arrangements and advance funds for a qualified person to go home with the child as their attendant.

	We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.
Travel expenses of family members	Allianz Global Assistance will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.
Returning you home (repatriation)	If you die while out of the province where you live, Allianz Global Assistance will pay up to $5,000 to do the following: • arrange for all necessary government authorizations. • arrange for the return of your remains in an approved container.
Returning your vehicle	Allianz Global Assistance will arrange and, if necessary, advance funds up to $500 to return a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from doing so.
Lost luggage or documents	If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Allianz Global Assistance will direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
Limits on advances	Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.
Reimbursement of expenses	If you obtain confirmation from Allianz Global Assistance that you are covered and a medical emergency exists, Sun Life will reimburse you for services and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Allianz Global Assistance. Allianz Global Assistance's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-866-881-0583. Allianz Global Assistance will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Allianz Global Assistance before your claim can be processed.
Coordination of coverage	If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Your responsibility for advances	You will have to reimburse Sun Life for any of the following amounts advanced by Allianz Global Assistance: • any amounts which are or will be reimbursed to you by your provincial medicare plan. • that portion of any amount which exceeds the maximum amount of your coverage under this plan. • amounts paid for services or supplies not covered by this plan. • amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you. Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received.
Limits on Emergency Travel Assistance coverage	There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before you leave on your trip. Allianz Global Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of: • a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident, terrorism or an act of God. • the refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.
Liability of Sun Life or Allianz Global Assistance	Neither Sun Life nor Allianz Global Assistance will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Care

Plan administrator

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

General description of the coverage

The contract holder is wholly responsible for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the employee and all dependents covered for Dental Care benefits.

Dental Care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, we will only cover **reasonable expenses**. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

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

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

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

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

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

Your dental services at a glance

Covered expenses	Details / Payment limits
Preventive dental procedures – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.	
Oral examinations	• 1 complete examination every 2 benefit years. • 1 recall examination every 6 months for a person under age 18 or every 9 months for any other person. • emergency or specific examinations.
X-rays	• 1 complete series of x-rays or 1 panorex every 2 benefit years. • 1 set of bitewing x-rays every 6 months for a person under age 18 or every 9 months for any other person. • x-rays to diagnose a symptom or examine progress of a certain course of treatment.
Other services	• required consultations between two dentists. • polishing (cleaning of teeth) and topical fluoride treatment once every 6 months for a person under age 18 or every 9 months for any other person. Including 1 unit of scaling of 15 minutes in addition to scaling under Basic procedures. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth and related anaesthesia. • providing space maintainers for missing primary teeth. • pit and fissure sealants, only for persons under age 18. • oral hygiene instruction twice per lifetime.
	• treatment planning.
Basic dental procedures – Your dental benefits include the following procedures used to treat basic dental problems.	
Fillings	• amalgam (silver) and composite or acrylic (white), or equivalent. Replacements are limited to teeth for which the initial placement are at least 12 months old.

Covered expenses	Details / Payment limits
Extraction of teeth	• removing teeth, except impacted teeth (*Preventive dental procedures*).
Basic restorations	• prefabricated metal or plastic restorations and repairs to prefabricated metal or plastic restorations, other than in conjunction with the placement of permanent crowns.
Endodontics	• root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.
Periodontics	• treating disease of the gum and other supporting tissue, including management of oral manifestations of systemic disease or complications from medical therapy. • scaling and root planing, up to a combined maximum of 8 units of 15 minutes per benefit year, excluding scaling covered under *Preventive procedures.*
Oral surgery	• surgery, other than the removal of impacted teeth (*Preventive dental procedures*). Surgery includes, but is not limited to, movement of teeth (transplantation).
Anaesthesia	• anaesthesia, sedation and conscious sedation in conjunction with a dental procedure covered under this plan.
Habit breaking appliances	• appliances to control harmful habits.
Major dental procedures – Your dental benefits include the following procedures used to treat major dental problems.	
Major restorations	• inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal or plastic restorations (*Basic dental procedures*).
Repair of bridges	• repair of bridges.
Repair of dentures	• repair of dentures.
Rebase or reline	• rebase or reline of an existing partial or complete denture.
Prosthodontics	Construction and insertion of bridges or standard dentures, limited to teeth extracted while a person is covered under this provision. We do not consider charges for a replacement bridge or replacement standard denture an eligible expense during the 5 year period after a previous bridge or standard denture is constructed or inserted**, unless either 1. or 2. below is true:** 1. it is needed to replace a bridge or standard denture which has caused temporomandibular joint (TMJ) disturbances and which cannot be economically modified to correct the condition. 2. it is needed to replace a transitional denture which was inserted shortly after teeth were extracted, where the dentist cannot economically get it to the final shape needed.
Orthodontic procedures – Your dental benefits include the following procedures used to treat misaligned or crooked teeth.	
Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces	The following orthodontic procedures are covered: • interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*) or habit breaking appliances *(Basic dental procedures)*. • comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

When coverage ends

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

What is not covered

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

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

We will not pay for:

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

We will also not pay for dental work resulting from:

- teeth malformed at birth or during development.
- participation in a criminal offence.

Life Coverage

Insurer

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

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.

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

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

Who we will pay	If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. For your spouse's optional coverage, we will pay the full amount of the benefit to the last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to you.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 1 year, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions.
Coverage during total disability	Life coverage may continue without the payment of premiums if you become totally disabled before you retire or reach age 60, whichever is earlier, as long as you are totally disabled. This continued coverage must follow the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations. There are a number of rules and conditions in the group contract that apply to coverage during total disability. Please contact Sun Life for details.

Converting Life coverage

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

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

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

Employee and Family Assistance Program

Your Employee and Family Assistance Program (EFAP) is provided by Morneau Shepell. The CP Employee and Family Assistance Program (EFAP) provides you with immediate and confidential help for any work, health or life concern. We are available anytime and anywhere. Let us help.

Solutions for your work, health and life

Achieve well-being
• Stress • Mental health concerns • Grief and loss • Crisis situations

Manage relationships and family
• Communication • Separation/divorce
• Parenting

Deal with workplace challenges
• Stress • Performance • Work-life balance

Tackle addictions
• Alcohol • Drugs • Tobacco • Gambling

Focus on your physical health
• Understand symptoms
• Improve sleep

Find child and elder care resources
• Child care • Schooling • Nursing / Retirement homes

Get legal advice
• Family law • Separation/divorce • Custody

Receive financial guidance
• Debt management • Bankruptcy • Retirement

Improve nutrition
• Weight management • High cholesterol and blood pressure • Diabetes

Understanding your EFAP

Your EFAP is a confidential and voluntary support service that can help you take the first step toward change.
Let us help you find solutions to the challenges you face at any age and stage of life. You and your immediate family members (as defined in your employee benefit plan) can access immediate and confidential support in a way that is most suited to your preferences, comfort level and lifestyle.

No Cost

There is no cost to you or your family to use your EFAP. This benefit is provided to you by CP. Your EFAP can provide a series of sessions with a professional and if you need more specialized or longer-term support, our team of experts can suggest an appropriate specialist or service that is best suited to your needs. While fees for these additional services are your responsibility, they may be covered by your provincial or CP health plan.

Access your EFAP 24/7 by phone, web or mobile app

1.800.735.0286 TTY 1.877.338.0275

workhealthlife.com

Weekly Indemnity Benefit

Canadian Pacific - TCRC

Billing Group 117-171: TCRC - Teamsters Canada Rail Conference

Weekly Indemnity Benefit (WIB)

Your Weekly Indemnity Benefit is provided by Canadian Pacific. Morneau Shepell has been contracted to adjudicate and administer your non-occupational claims for this benefit following the Weekly Indemnity Disability Benefit Plan. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

You are responsible for the completion of the claims forms and shall provide written Proof of Disability to Morneau Shepell as shall be deemed necessary and appropriate by Morneau Shepell.

If you become Totally Disabled while covered and meet the Entitlement Criteria for this benefit, Canadian Pacific will pay a disability benefit.

Note: Employees with work-related (occupational) injuries, must apply for Workers' Compensation Benefits (WCB).

This program is governed by the official documents, such as the Collective Bargaining Agreement, as well as by applicable legislation. In the event of any inconsistency between this document and the official documents, the latter will prevail. CP reserves the right to suspend, amend or terminate any or all benefits.

Definitions

Appropriate Treatment - means treatment which meets all the following conditions:

- it is performed and prescribed by a Doctor, or when deemed necessary by the Morneau Shepell, by a medical specialist and
- it is of a reasonable and customary nature and treatment is provided with a frequency usually required for the condition
- the care provided to you is of demonstrable medical value for the condition, and
- it is not solely limited to examinations and/or testing

Assigned Rest Day - means a rest day to which an Employee is entitled as defined by the terms of the Master Agreement.

Base Pay - Unless otherwise provided herein, any change in the Amount of disability Benefit will take effect on the date of change in the Eligible Employee's earnings subject to the following:

- For hourly rated Employees, Base Pay is the product of the Employee hourly rate multiplied by the number of regularly scheduled hours per week.
- For daily rated Employees, Base Pay is the product of the Employee daily rate multiplied by the number of regularly scheduled days per week.
- For monthly rated Employees, Base Pay is the quotient of the Employee monthly rate divided by 4 1/3.
- For mileage basis Employees, Base Pay is the weekly average of the Employee miles paid for within the six Pay Periods immediately preceding the date of commencement of disability.
- For spare board, relief, casual or similar type of Employees, Base Pay is the weekly average of the Employee's earnings during the six consecutive complete Pay Periods in which the Employee received earnings immediately preceding the date of commencement of disability.

If an Eligible Employee is not actively at work full time on the date an increase would otherwise take effect, it will take effect only when he is again actively at work.

Canadian Pacific Railway Company (Canadian Pacific) - includes those subsidiary and jointly owned companies for which and on whose behalf Canadian Pacific Railway Company executed the Master Agreement.

Disability or Disabled - that an Eligible Employee has become wholly and continuously disabled from bodily injury

or from sickness or disease so as to be prevented from performing the essential duties of his regular occupation or regular employment.

Disability Benefits - On receipt by Morneau Shepell of proof as herein required that an Eligible Employee has become wholly and continuously disabled from bodily injury or from sickness or disease so as to be prevented from performing the essential duties of his occupation or employment, a benefit will be paid to such Eligible Employee equal to one-seventh of the weekly Amount of Disability Benefits to which the Eligible Employee was entitled on the date he became so disabled for each day that he continues to be so disabled and does not engage in any occupation or employment for wage or profit, subject to the limitations set out in hereof. To which the Eligible Employee was entitled on the date he became so disabled

The availability of work will not be considered by Morneau Shepell or Canadian Pacific in assessing your disability.

Benefits are payable from the end of the elimination period. Benefits are not payable for or during the elimination period. The Employee must be receiving regular, ongoing care and treatment from a Physician during the elimination period in order for benefits to be payable at the end of the elimination period. Otherwise, benefits will not be payable until the date the Employee is first treated by his physician.

Such benefit will commence with:

- with the first (1st) such day if disability is due to bodily injury effected directly and independently of all other causes through accidental means;
- with the fourth (4th) such day if disability is due to sickness or disease;
- with the first (1st) such day if the Eligible Employee is confined to Hospital at any time during one period of disability; and
- with the first (1st) such day if the Eligible Employee has day surgery performed at any time during one period of disability; and
- if the Eligible Employee is undergoing a colonoscopy – the day proceeding the day of the colonoscopy.

Benefits will continue for not more than the Maximum Indemnity Period set out hereof during any one period of disability whether disability is due to one or more causes. Benefit payments will be made bi-weekly.

Disability Benefit and Group Insurance Plan Agreement - means the agreement entered into between Canadian Pacific Railway Company and the unions.

Disability Benefit Plan - means the Disability Benefit Plan described herein.

Doctor - means a qualified physician or surgeon duly licensed to practice medicine and a fully qualified physician who meets all the following conditions:

- is duly authorized and licensed to practice medicine in the province in which treatment is being rendered to you and who is registered in good standing with the College of Physicians and Surgeons in such province
- is neither you nor a member of your immediate family
- is qualified to treat your disabling condition
- provides treatment within the scope of his or her license

Effective Date of the Benefit Plan - means January 1, 2020.

Eligible Employee - An Employee whose Service commenced on or before the Effective Date of the Plan shall become an Eligible Employee on the later of

- January 1, 1986, or
- the first day of the month following the particular month he has rendered compensated service as a TCRC employee with an employing railway in a position subject to one or more of the collective agreements or an employing railway on such day.

An Employee whose Service commences after the Effective Date of the Plan (January 1, 1986) shall become an Eligible Employee on the first day of the month following the particular month he has rendered compensated service as a TCRC employee with an employing railway, in a position subject to one or more of the collective agreements, provided he is actively at work for an employing railway on such day.

If an Employee is not actively at work on the date he would have become an Eligible Employee, such Employee shall become an Eligible Employee:

- on such day if the sole reason for his absence from work on such day is a General Holiday or an Assigned Rest Day, or
- on the date on which he returns to full-time active work if his absence from work is for some reason other

than that it is a General Holiday or an Assigned Rest Day.

An Employee who has ceased to be an Eligible Employee by reason of temporary lay-off, leave of absence, off-duty account mileage regulations, vacation, suspension or strike, shall become an Eligible Employee on the date of his return to full-time active work.

Elimination Period - means those days subsequent to the disability of an Eligible Employee for which such Eligible Employee is not entitled to Disability Benefits.

The Elimination Period for a disability due to accident is nil. The Elimination Period for a disability due to sickness is three (3) days, or if the Eligible Employee is hospitalized during the period of disability for which claim is being made, nil.

Employee -

- an employee in the service of a Railway who qualifies as an Eligible Employee in accordance with the provisions hereof, or
- an employee in the service of a Railway who is a member of a group admitted pursuant to the plan.

For the purpose of this Disability Benefit Plan, any reference to a participating employee will be deemed to include an admitted employee.

General Holiday - means any of the days defined in the applicable Collective Agreement as a General Holiday.

Hospital - means a legally operated institution which

- is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and
- provides such facilities under the supervision of a staff of Doctors with a 24 hour a day nursing service by registered nurses, and
- is not principally a home for the aged, rest home, nursing home or a place for the care and treatment of drug addiction or alcohol.

Hospitalization - means admittance to a Hospital as an in-patient. This includes being admitted to a Hospital as an out-patient for chemotherapy and medically necessary surgical procedures, but does not include laser treatment.

Master and/or Memoranda of Agreement - means the Agreement signed between Canadian Pacific Limited and the Teamsters Canada Rail Conference (TCRC) Union.

Maximum Indemnity Period –

- in respect of an Eligible Employee who is covered through a Railway under a supplemental payment procedure approved by Human Resources and Skills Development Canada, is 26 weeks plus the number of weeks the Employee is entitled to Employment Insurance Sickness Benefits, but not to exceed 41 weeks for any one period of disability.
- in respect of an Eligible Employee who is not covered through a Railway under a supplemental payment procedure approved by Human Resources and Skills Development Canada, is 26 weeks for any one period of disability.
- for Maternity Leave, in respect of an Eligible Employee who is covered and in receipt of payments through a railway under a supplemental payment procedure approved by Human Resources and Skills Development Canada, is 15 weeks.

Pay Period - means two weeks.

Pregnancy - means pregnancy, childbirth, miscarriage, abortion and conditions which result directly or indirectly from any of these.

Proof of Disability - any statement made on forms approved for making a claim under this Plan approved for such purpose by and received by the office designated by Morneau Shepell, along with such additional documentation as may be deemed necessary and appropriate by Morneau Shepell for making such claim.

Railway - means Canadian Pacific Railway Company and its subsidiaries and joint properties listed in the Master Agreement, and also includes an employer associated with one of the Railways a group of whose Employees has been admitted as provided in the Disability Benefit and Group Insurance Plan Agreement

Service - means compensated employment with a Railway.

Waiting Period – the period of continuous employment with your employer which you must complete before you are

eligible for Group Benefits.

The Benefit

Benefit Amount:

Amount of Disability Benefit to which an Eligible Employee is entitled.

Benefit:

$120.01 and over: 70% of weekly base pay to a maximum benefit equal to the current Employment Insurance maximum benefit amount or the Maximum Benefit, whichever is greater.

Less than $120.01: $80 or 75% of the Employee's weekly base pay, whichever is less.

Employees who are eligible for Employment Insurance:

- for the first 15 weeks of benefit payment, 70% of weekly earnings, to a maximum benefit equal to the current Employment Insurance Maximum benefit amount or the Maximum Benefit, whichever is greater
- for the 16th to 30th weeks of benefit payment, 70% of weekly earnings, to a maximum benefit equal to the current Employment Insurance Maximum benefit amount or the Maximum Benefit, whichever is greater, less any amount payable by Employment Insurance
- for the 31st and subsequent weeks of benefit payment, 70% of weekly earnings, to a maximum benefit equal to the current Employment Insurance Maximum benefit amount or the Maximum Benefit, whichever is greater

Maximum Weekly Benefit - $800 (for claims which originate on or after January 1, 2020)

Claims which originate on or after January 1, 2021, Maximum Benefit: $825

Maximum Benefit Period:

Employees who are not eligible for Employment Insurance: 26 weeks

Employees who are eligible for Employment Insurance: 41 weeks

Elimination Period - none, if the disability is due to an accident; three (3) calendar days, if the disability is due to a sickness

- If hospitalized due to sickness prior to the end of the Elimination Period, benefits are payable from the first day of hospitalization.
- If you are undergoing a colonoscopy, benefits will be payable from the day preceding the day of the colonoscopy.
- Benefits are payable from the end of the Elimination Period. Benefits are not payable for or during the Elimination Period.
- You must be receiving regular, ongoing care and treatment from a physician during the Elimination Period in order for benefits to be payable at the end of the Elimination Period. Otherwise, benefits are not payable until the date you are first treated by your physician.

Termination Age - your benefit amount terminates at age 65 or retirement, whichever is earlier

Waiting Period - 1st of the month following the first day worked

If an Employee is not actively at work on the date he would have become an Eligible Employee pursuant hereof, such Employee shall become an Eligible Employee:

- on such day if the sole reason for his absence from work on such day is a General Holiday or an Assigned Rest Day, or
- on the date on which he returns to full-time active work if his absence from work is for some reason other than that it is a General Holiday or an Assigned Rest Day.

An Employee who has ceased to be an Eligible Employee pursuant hereof by reason of temporary lay-off or leave of absence, shall become an Eligible Employee on the date of his return to active work.

Employee Responsibilities

An Eligible Employee shall be responsible for the completion of the claim forms and shall provide proof of disability as shall be deemed necessary and appropriate by Morneau Shepell.

Comply with the application process and notice. Written proof of claim must be provided to Morneau Shepell within

30 days after the date of the accident causing the injury or the date of commencement of the disability from sickness or disease and subsequent proofs of claim as Morneau Shepell may require at intervals not more often than weekly. Failure to provide proof within the time specified will not invalidate the claim if it is shown that it was not reasonably possible to provide proof within such time and that proof was provided as soon as reasonably possible.

Any proof of claim involving medical evidence in respect of an Eligible Employee shall be provided without expense to Morneau Shepell and shall be signed by the Doctor personally attending the Eligible Employee. Morneau Shepell will have the right, at its own expense, to have Doctors designated by it examine any person in respect of whom a claim is being made when and as often as it may reasonably require.

Medical evidence received from nurse practitioners will be considered. Morneau Shepell will allow for up to four (4) weeks of initial treatment by a nurse practitioner if deemed appropriate. Should the period of disability be extended beyond four weeks the expectation is that a Doctor should be consulted.

Any Employee who is denied all or any part of a claim for reimbursement by Morneau Shepell shall receive, from Morneau Shepell, a notice in writing setting forth the specific reasons for such denial, specific reference to the Disability Benefit Plan's provisions on which the denial is based, a description of any additional material necessary for such Employee to support the claim, and explanations both as to why such material is necessary and as to the terms of the Disability Benefit Plan's claims review procedure, all written in a manner calculated to be understood by such Employee whose claim has been denied.

Recover from the disability, including securing Appropriate Treatment and participating in any reasonable treatment or Rehabilitation Program and accepting any reasonable offer of Modified Work from the Employer.

Submit to additional examinations including but not limited to a Functional Abilities Evaluation or Independent Medical Evaluation as requested by the Employer (Occupational Health Services), Doctor or Morneau Shepell.

Obtain benefits that may be available from other sources

Apply for government-sponsored benefits

Assist in recovering damages from a third party responsible for your illness or injury

Submitting a Claim

To submit a claim, you must report a medical absence from work by notifying your Manager/Supervisor or their designate, prior to start of your shift or at the earliest opportunity.

You must notify your Manager for each day of absence until either you have returned to work or missed three (3) consecutive days (unless disability is due to accident, day surgery or hospitalization), following which the Weekly Indemnity process will be initiated by your Manager through Canadian Pacific's Status Change Form.

If your absence exceeds three (3) consecutive days (unless disability is due to accident, day surgery or hospitalization), your Manager/Supervisor or their designate will submit a Status Change Form to Canadian Pacific Employee Services who will submit your WIB referral. Within one (1) business day of submitting your referral, you will receive an outreach call from your Morneau Shepell Case Manager who will provide you with more details regarding next steps, the required consent form and any physician forms that may be required.

For any planned surgery or hospitalization, you may report your medical absences up to two (2) weeks in advance.

A completed claim must be provided to Morneau Shepell within **30 days** after the date of the accident causing the injury or the date of commencement of the disability from sickness or disease.

Your attending physician may be required to complete an Attending Physician's Form; your Morneau Shepell Case Manager will provide this instruction as well as a copy of the form to you. Please note the Functional Ability Form (FAF) and Attending Physician Form have now been combined and should be returned to Morneau Shepell as directed on the form. You may also access this form on **CP Station > Employees > Disability Management**

Should you have additional questions, please consult the Frequently Asked Questions (FAQ) on **CP Station > Employees > Disability Management** and/or contact the CP Rail Disability Management Team by email at:

- RTW_-East@cpr.ca for Employees located in ON and QC or
- RTW_-West@cpr.ca for Employees located in MB, SK, AB, BC

Entitlement Criteria

To be entitled to disability benefits, you must meet the following criteria:

- you must be continuously Totally Disabled throughout the Elimination Period
- your employer or Morneau Shepell must receive medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation
- you must be receiving from a physician, regular, ongoing care and treatment appropriate for your disabling condition, as determined by your employer or Morneau Shepell.
- At any time, your employer or Morneau Shepell may require you to submit to a medical, psychiatric, psychological, functional, educational and/or vocational examination or evaluation by an examiner selected by your employer or Morneau Shepell.
- if an Eligible Employee becomes so disabled and his 15th week of benefit payment ends on any day other than a Saturday, the benefit payments will be extended until the Saturday following the end of the benefit payments.
- if an Eligible Employee becomes so disabled and while so disabled there is a General Holiday, he will be entitled to benefit payments for such General Holiday only if the Eligible Employee receives no pay for the General Holiday.
- if an Eligible Employee becomes so disabled and while so disabled there is an Assigned Rest Day, he will be entitled to benefit payments for the Assigned Rest Day.
- if an Eligible Employee becomes so disabled and while so disabled is subsequently laid-off, he will be entitled, while laid-off and still disabled, to benefit payments as they fall due as if he had not been laid-off.
- if an Eligible Employee is laid-off, on leave of absence, off duty on account of mileage regulations, on vacation, on suspension or on strike, and subsequently becomes disabled and if while so disabled such Eligible Employee is due to return to work with the Company but because of his disability he cannot return to work, he will be entitled to benefit payments on the date he would have returned to work had it not been for such disability.
- if an Eligible Employee entitled to benefits hereunder is covered through a Railway under a supplemental payment procedure approved by Human Skills and Resources Development Canada, such a disabled employee is entitled to the difference, if any, between the sickness benefit payable under the Employment Insurance Act and the amount otherwise payable under this plan, for any period after 15 weeks of disability, up to and including 30 weeks of disability, during which the employee is entitled to receive Employment Insurance Sickness Benefits.
- if an Eligible Employee entitled to benefits hereunder in respect of a period of disability qualifies, by virtue of being insured under any other scheme whether arranged with an insurer or provided by any association, for daily, weekly or monthly indemnity benefits, excluding any private insurance plan the claimant may have, for all or any portion of such period of disability, benefits payable to such Eligible Employee will be reduced by such part of the amount of benefits payable under such other scheme for such period or portion of such period of disability as may be deemed by Morneau Shepell to constitute over-insurance in respect of such Eligible Employee.
- if an Eligible Employee, while on maternity leave is eligible for Unemployment Insurance Maternity Benefits, that employee will have such Benefits supplemented (topped-off) by this Plan so as to equal the amount of Disability Benefits under this Plan for a maximum period of 15 weeks.
- if a Doctor certifies in writing that an Eligible Employee who is pregnant or nursing cannot continue in her own job because of the risk it might pose to the Eligible Employee, the unborn child or the child, and the Railway decides that it is not practical to reassign the Eligible Employee or modify her job functions, the Eligible Employee will be granted a leave of absence starting on the date the Railway advises the Eligible Employee of its decision. The Eligible Employee will be considered disabled and will fall under the provisions of the Disability Plan. The maximum duration of the leave of absence is from the beginning of the pregnancy until the last day of the 35th week following the end of the pregnancy.
- if a Doctor certifies in writing that an Eligible Employee who is pregnant or nursing cannot continue to work

because of the risk it might pose to the Eligible Employee, the unborn child or the child, the Eligible Employee will be granted a leave of absence starting on the date the Doctor certifies that such condition exists. The Eligible Employee will be considered disabled and will fall under the provisions of the Disability Plan. The maximum duration of the leave of absence is from the beginning of the pregnancy until the last day of the 35th week following the end of the pregnancy.

Periods for Which You are Not Entitled to Benefits

You are not entitled to benefit payments for any period that:

- you are not receiving from a physician, regular, ongoing care and Appropriate Treatment for your disabling condition, as determined by your employer or Morneau Shepell
- during which you are not following the Appropriate Treatment
- that you are receiving Employment Insurance, maternity or parental benefits
- that you are on lay-off during which you became Totally Disabled
- you do not supply your employer or Morneau Shepell with medical evidence documenting how your illness or injury causes restrictions or lack of ability such that you are prevented from performing the essential duties your own occupation
- after you fail to participate and cooperate in a medical, psychiatric, psychological and/or functional examination or evaluation by a medical examiner selected by Morneau Shepell
- you are on leave of absence during which you become Totally Disabled, unless your employer is required to pay benefits during this period as a result of legislation, regulation or case law
- that you are receiving benefits under any other employer-sponsored salary continuance or wage loss replacement plan, or receiving temporary disability benefits from Workers' Compensation
- you are receiving earnings or payments from any employer, including severance payments and vacation pay
- you are incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court

Reduction to Amount of Disability Benefit Payable

The amount of disability benefit payable to you is the Benefit Amount shown above reduced by any disability benefits you receive or are entitled to receive from the following source(s) for the same or related disability:

- disability or retirement benefits payable to the Employee under the Canada Pension Plan or Quebec Pension Plan, excluding any cost of living increases that occur after benefits begin;
- a judgment or settlement that the Employee receives from a third party (subrogation) in connection with or resulting from the Employee's disability;
- any amount of income or benefit payable to the Employee under a motor vehicle insurance plan, where legally permitted and received in connection with or resulting from the Employee's disability;
- any daily, weekly or monthly indemnity benefits received from any other private or public insurance plan or policy
- any other government sponsored benefit received in connection with or resulting from the Employee's disability.
- from Workers' Compensation or similar coverage
- from your employer-sponsored salary continuance or wage loss replacement Plan
- as earnings from your employer, including severance and vacation pay as set out in the Employment Insurance Program

Benefit Calculation Rules

Your employer or Morneau Shepell will apply the following rules in determining your disability benefit:

- benefits payable from other sources which began before the commencement of your current disability will not be taken into account
- benefits payable from other sources will not be adjusted to take into account any difference between the tax status of those benefits and the benefit payable by Morneau Shepell
- for benefits payable other than on a weekly basis, a weekly equivalent of such benefit will be estimated by your employer or Morneau Shepell

Payment of Disability Benefits

Disability benefit payments will be made bi-weekly in arrears. Any payment for a period of less than one week will be made at a daily rate of one-seventh of your weekly benefit amount.

Tax Status of Benefits

The tax position of any payments you receive under this benefit depends on whether you or your employer pays the cost of the benefit. If your employer pays a portion or all of the cost, then any disability benefit payments you receive will be taxable. If you pay the full cost of the benefit, then any disability benefit payments you receive will be non-taxable.

As your employer pays for the full cost of the WIB, any disability payments received will be considered as taxable income.

Rehabilitation Assistance

Once your employer or Morneau Shepell determines that you are Totally Disabled, if appropriate, and at your employer or Morneau Shepell's discretion, you may be offered rehabilitation to assist you in returning to work.

In considering whether Rehabilitation Assistance is appropriate for you, your employer or Morneau Shepell will take into account:

- the nature, extent and expected duration of your disability
- your level of education, training or experience
- the nature, scope, objectives and cost of a Vocational Plan

Vocational Plan

A Vocational Plan is a training or job placement program that is expected to facilitate your return to work.

If it is determined that Rehabilitation Assistance is appropriate for you, in partnership with you, your employer or Morneau Shepell will provide a structured Vocational Plan that will prepare you for a return to work with your employer.

Disability Benefits During Rehabilitation

You will continue to be entitled to disability benefits while participating in the Vocational Plan. If you receive any earnings as part of the plan, your disability benefit will be reduced once your total income (your disability benefit plus your earnings) exceeds 100% of your pre-disability gross earnings.

If you cease to participate in the Vocational Plan because of a change in your medical status, your employer or Morneau Shepell will require medical evidence documenting how your current medical status prevents you from continuing with the Vocational Plan.

If you are not available or do not co-operate or participate in the Vocational Plan, you will no longer be entitled to disability benefits.

Termination of Benefit Payments

Your disability benefit payments will cease on the earliest of:

- the date the Eligible Employee's Service with a Railway terminates,
- the last day worked prior to a strike in which the Eligible Employee ceases to work,
- in the event of an Eligible Employee ceasing to be eligible for coverage hereunder for any reason other than termination of Service with a Railway, the date on which he ceases to be eligible,
- the date of termination of this Disability Benefit Plan,
- The date the Eligible Employee is laid-off, for an Employee who is advised of a lay-off prior to commencement of disability,
- the date the eligible employee attains age 65, retires or date of death, whichever is earlier
- the date you work in any occupation for wage or profit
- the date you do not supply your employer or Morneau Shepell with appropriate medical evidence documenting how your illness or injury causes restrictions or lack of ability, such that you are prevented from performing the essential duties of your own occupation
- the date you do not attend an examination by an examiner selected by your employer or Morneau Shepell
- the date you cease to be Totally Disabled, as defined under this benefit
- the date on which benefits have been paid up to the Maximum Benefit Period for this benefit

Termination of an Eligible Employee's Service shall, for the purposes of this Disability Benefit Plan, be deemed to occur on the date on which such Eligible Employee discontinues active work (including retirement) with a Railway, except that Service will be deemed to continue:

- during any period the Eligible Employee is entitled to Disability Benefits or Employment Insurance Sickness Benefits,
- during any period in accordance with the Union Expiry Rules during which the Eligible Employee is entitled to benefits under Workers' Compensation legislation,
- during any period the Eligible Employee is on bereavement leave or Railway compensated jury duty, or for union officers on temporary leave of absence to perform union duties and who have Service in the current or previous month, or in accordance with the Union Expiry Rules, or

Recurrent Disability

If you become Totally Disabled again from the same or related causes:

If after the termination of a disability, for which an Eligible Employee was entitled to a benefit, such Eligible Employee again becomes disabled due to the same or related cause or causes, such later disability will be considered as a continuation of the previous disability for the same amount of Disability Benefit and subject to the same Maximum Indemnity Period but without the application of another Elimination Period unless:

- such Eligible Employee had completely recovered from the previous disability and had been at work with a Railway on full time as required by such Railway for a period of at least two (2) consecutive weeks after termination of the previous disability, or
- such Eligible Employee, though not completely recovered from the previous disability, had been at work with a Railway on full time as required by such Railway for a period of at least four (4) consecutive weeks after termination of the previous disability.

If after the termination of a disability, for which an Eligible Employee was entitled to a benefit, such Eligible Employee again becomes disabled due to an unrelated cause or causes, such later disability will not be considered as a continuation of the previous disability if it is separated from the previous disability by a period during which the Eligible Employee was actively at work.

You will not be required to satisfy any applicable Elimination Period again. The benefit payable to you will be based on your earnings as at the date of your previous disability. Benefits for all such recurrent disabilities will not be paid

for a combined period longer than the Maximum Benefit Period for this benefit.

If the same disability recurs more than two (2) weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two (2) disabilities which are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Appeals

If your claim has been denied in whole or part by Morneau Shepell, you may submit within **30 calendar days** after such denial, information and materials in support of the claim to Morneau Shepell.

Within **20 business days** of receiving your submission, and any additional medical or other information that may be required to process the appeal, Morneau Shepell shall review the claim and make a determination and such determination shall be final, in writing, including specific reasons for the decision and specific reference to the Disability Benefit Plan provisions on which it is based, written in a manner calculated to be understood by you. In connection with any such review, you will be permitted to examine documents relating to the issues on appeal, and to submit issues and comments in writing.

Subrogation

If your disability is caused by another person and you have a legal right to recover damages, your employer will request that you complete a subrogation reimbursement agreement when you submit your Weekly Indemnity claim.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the disability benefits that your employer paid to you, exceed 100% of your lost income.

Third Party Liability

If you have a cause of action against a third party for loss of income which could have been earned while disability benefits are paid or payable under this Plan resulting from your disability, you shall assist your employer or Morneau Shepell in the recovery of damages from a third party. Morneau Shepell has the right to withhold or discontinue disability benefits if you refuse or fail to comply with any of the terms of this provision. You shall provide free of charge:

- a written statement of the circumstances that caused your disability, including any facts that may give you a legal claim against another person, organization or company that caused the disability (a “third party”)
- prompt notice of the commencement of any legal proceedings against a third party
- a signed reimbursement and direction form acknowledging that you are bound by this provision
- reports on the status of the legal proceedings or settlement negotiations as reasonably requested by Morneau Shepell
- copies of any documents in your possession or control relating to your claim against the third party
- prompt notice of any settlement or judicial disposition of the legal proceedings.

The amount the Employee shall reimburse your employer or Morneau Shepell shall be determined by the amount recovered by the Employee for loss of income through settlement with or without judgement against a third party, including interest thereon.

Exclusions

Payment will not be made under the Disability Benefit Plan:

- for any period of disability during which the Eligible Employee is not following the Appropriate Treatment for the disabling condition.
- for any period for which indemnity or compensation is payable under Workers' Compensation legislation, unless such indemnity or compensation is payable in respect of a previously incurred partial disability which permits continuation of employment by the Eligible Employee.

- for that portion of any period of disability during which the Eligible Employee is in receipt of retirement pension from a Railway, or General Holiday or vacation pay is payable. However, an Eligible Employee who becomes disabled during his annual vacation may temporarily terminate the vacation to qualify for Disability Benefits.
- for any period of disability commencing after the time the Eligible Employee goes on strike.
- for any period more than 15 weeks from the date of disability, if subsequent to disability the Eligible Employee's union goes on strike.
- for any period during which the Eligible Employee is engaged in any occupation for wage or profit.
- in respect of total disability as a result of Pregnancy:
    - for any period commencing with the tenth week prior to the expected week of confinement and ending with the sixth week after the week of confinement, or
    - during any period of formal maternity leave taken by the Eligible Employee pursuant to provincial or federal law or pursuant to mutual agreement between the Eligible Employee and her Railway except that during any period for which the Eligible Employee is paid maternity benefits under the Employment Insurance Act, benefits are payable hereof.
- in respect of disability directly or indirectly due to or resulting from any of the following:
    - bodily injury sustained while doing any act or thing for wage or profit other than on behalf of a Railway,
    - intentionally self-inflicted injuries, unless medical evidence establishes that the injuries are related to mental illness,
    - war, insurrection or the hostile action of the armed forces of any country, or participation in any riot or civil commotion,
    - any cause for which indemnity or compensation is payable under Workers' Compensation legislation.
- during any period during which the employee is on vacation, off duty on account of mileage regulations, on leave of absence, suspended or laid-off.
- during any period during which the Eligible Employee does not suffer a wage loss.
- medical or surgical care which is not medically necessary
- the committing of or the attempt to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle under the influence of any intoxicant, including alcohol
- for any period of disability during which the Eligible Employee is an inmate of a prison or similar institution.
- for an illness or injury resulting from a motor vehicle accident (MVA) that is covered by a provincial MVA insurance plan which provides benefits in respect of the actual or presumed loss of income from employment due to injury
- elective surgery, including corrective eye surgery and hair transplant. However, disabilities related to elective surgery for live organ donation, vasectomies, tubal ligations and gender dysphoria may be considered covered, upon pre-approval by your employer or Morneau Shepell to determine eligibility.

General Provisions

In the event of the death or total mental or physical incapacity of the Participating Employee all accrued disability benefit shall be payable to the estate of the Participating Employee, provided, however, that Morneau Shepell may, with the approval from the Railway, pay such accrued disability benefit to any one of the following: wife, mother, father, child or children (if of the full age of majority), or any other person who is entitled to such payment by reason of having incurred expense for the maintenance, medical attendance or burial of the deceased.

Morneau Shepell is under no obligation to see to the application of any moneys so paid and any such payment shall constitute a complete discharge to Morneau Shepell to the extent of the amount of the payment.

No action or proceeding against Morneau Shepell in connection with any claim under the Plan may be commenced earlier than sixty days nor later than two years from the expiration of the time within which proof of such claim is required.

Basic Accidental Death and Dismemberment

Insurer

This benefit is insured by AIG Insurance Company of Canada.

POLICY No : BSC 9142124
For : Canadian Pacific Railway Company
Divisions: USW, Unifor, IBEW, CPPA, RCTC, TCRC

Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer has provided for you with Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance or use of a limb, sight, speech or hearing.

How It Works

You are automatically covered for a Principal Sum amount matching your basic life benefit

If loss of life is due to a work related accident or while in the course of performing Union related work, a benefit amount of $150,000 will be payable to the beneficiary stated in your Basic Group Life coverage in lieu of the Accidental Loss of Life benefit.

Here's What You Get

Broad Accident Insurance Coverage—Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

Guaranteed Acceptance—Coverage is provided regardless of your health history.

24/7 Worldwide Coverage—Your coverage is in force around-the-clock—at work, at home or at play, anywhere in the world.

Definitions

"Insured Employee" means you, if you are a permanent, full-time unionized employee of the Policyholder who is under the age of 70.

Eligible Dependents:

"Spouse" means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

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

Beneficiary Designation

You have the option to designate a beneficiary, should you choose not to, in the event of accidental loss of life, the

benefit will be paid to the beneficiary you have designated in writing under your employer's current group life policy. If there is no written designation then the benefit will be paid to your estate.

All other benefits will be payable to you.

Benefits and Coverages

Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

Table of Losses

Loss of life ..... The Principal Sum
Loss of both hands or both feet ..... The Principal Sum
Loss of entire sight of both eyes ..... The Principal Sum
Loss of one hand and one foot ..... The Principal Sum
Loss of one hand and the entire sight of one eye ..... The Principal Sum
Loss of one foot and the entire sight of one eye ..... The Principal Sum
Loss of one arm or one leg ..... Four-fifths of the Principal Sum
Loss of one hand or one foot ..... Three-quarters of the Principal Sum
Loss of the entire sight of one eye ..... Three-quarters of the Principal Sum
Loss of thumb and index finger of the same hand ..... One-third of the Principal Sum
Loss of speech and hearing ..... The Principal Sum
Loss of speech or hearing ..... Three-quarters of the Principal Sum
Loss of hearing in one ear ..... Two-thirds of the Principal Sum
Loss of four fingers of one hand ..... One-third of the Principal Sum
Loss of all toes of one foot ..... One-quarter of the Principal Sum

Loss of Use

Loss of use of both arms or both hands ..... The Principal Sum
Loss of use of one hand or one foot ..... Three-quarters of the Principal Sum
Loss of use of one arm or one leg ..... Four-fifths of the Principal Sum

Paralysis

Quadriplegia (total paralysis of both upper and lower limbs)……Two times The Principal Sum up to a ……maximum of one million dollars
Paraplegia (total paralysis of both lower limbs)……Two times The Principal Sum up to a ……maximum of one million dollars
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)……..Two times The Principal ……Sum up to a maximum of one million dollars

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to "Quadriplegia", "Paraplegia", and "Hemiplegia" means the complete and irreversible paralysis of such limbs; "Hand" or "Foot" means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; "Arm" or "Leg" means the complete severance through or above the elbow or knee joint; "Thumb and Index Finger" means the complete severance through or above the 1st phalange; "Fingers" means the complete severance through or above the 1st phalange of all Four Fingers of One Hand; "Toes" means the complete severance of both phalanges of all the Toes of One Foot; "The Entire Sight of One Eye" means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; "The Entire Sight of Both Eyes" means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; "Hearing in One Ear" means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Hearing" means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; "Speech" means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of use provided the Loss is continuous for twelve consecutive months and such Loss of use is determined to be permanent. "Loss" when used herein may also include "Loss of Life".

Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory

Workplace Modification and Accommodation Benefit

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with the Policyholder.

Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) $1/30^{th}$ of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return the body to the city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

Identification Benefit

Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify the body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which the seat belt was properly fastened.

Day Care Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Dependent Child Educational Benefit

Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

Spousal Educational Benefit

Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income, if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

Funeral Expense

Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

Bereavement Benefit

Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

Waiver of Premium

Waives premium payments under the Plan if you are receiving disability benefits under the group life insurance policy provided by the Policyholder.

Continuance of Coverage

Your coverage will continue for up to 12 months during a temporary lay-off, short-term disability leave, approved leave of absence or maternity leave provided premiums are paid.

Conversion Privilege Benefit

If you leave your job for any reason, you have 90 days to convert your coverage under the Plan to an individual insurance policy providing comparable coverage and with a coverage amount not greater than the Principal Sum at individual rates in force at that time.

Policy Exclusions

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

(a) suicide or any attempt thereat by you while sane;

(b) self inflicted injury or any attempt thereat by you while sane or insane;

(c) declared or undeclared war or any act thereof;

(d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;

(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

(f) sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;

(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:

I. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

II. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

III. riding as a passenger in an aircraft owned or leased by the Policyholder;

(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

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

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

(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

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

(o) natural causes.

Aggregate Limit Per Accident

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

Effective Date

Your coverage begins on the date you satisfy the definition of “Insured Employee”.

Termination Date

Coverage ends on the earliest of:

(1) the date the policy is terminated; (2) the premium due date if premiums are not paid when due; (3) the date you no longer satisfy the definition of an Insured Employee; or (4) the first day of the month following the date you no longer belong to an Eligible Class of Employees as set out in the Policy.

This brochure provides only brief descriptions of the coverage available. The full details of the coverage are contained in the Policy including limitations, exclusions and termination provisions. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance is underwritten by AIG Insurance Company of Canada.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than one in six Canadians, in over 12,000 corporate, association, affinity and creditor groups across Canada.

Our Core values – integrity, service excellence, customer focus and building value – are at the heart of who we are and how we do business.

Sun Life Financial and its partners have operations in 22 key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
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