

**NAV CANADA INSURANCE PLANS FOR
UNIONISED EMPLOYEES**

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Foreword

The benefits in this booklet are intended for the use of NAV CANADA unionised employees.

The purpose of this booklet is to describe the insurance plans available to unionised employees, as follows:

Basic Life Insurance

Long-term Disability Insurance

Health Care

Supplementary Coverage
Comprehensive Coverage

Dental Care

Business Travel Accidental Death and Dismemberment

You are encouraged to read the contents of this booklet carefully. You should keep in mind that periodic changes are made to the insurance plans, which may include changes to benefits and to monthly premium rates. These changes will be announced on each occasion through the Pensions, Benefits, and Employee Health Programs Department. You are advised to keep a record of any announced changes, for reference, until this booklet is revised.

This booklet is intended for information purposes only, and describes the provisions of the insurance plans in general terms. The complete terms and conditions of the insurance plans are set out in the relevant Contract.

In case of conflict between this booklet and the relevant Contract, the terms of the Contract shall prevail.

Throughout this booklet, words importing the masculine gender include the feminine gender.

The Employer share of life insurance premiums is a taxable benefit under the Income Tax Act. The Employer share of Health Care Plan and Dental Care Plan premiums is a taxable benefit for all Québec residents. The applicable provincial sales tax is added to benefit premiums in the provinces of Ontario and Québec.

Introduction

The insurance plans for unionised employees are private plans provided by NAV CANADA.

NAV CANADA has appointed Sun Life Assurance Company of Canada (Sun Life) as its agent to review and pay claims and provide administrative services for health and dental care expenses. Such benefits are not insured by Sun Life but remain the responsibility of NAV CANADA.

The Great-West Life Assurance Company insures Life Insurance and Long-term Disability (LTD) benefits.

Business Travel Accidental Death and Dismemberment benefits are insured by CIGNA Life Insurance Company of Canada.

Any policy questions you may have regarding the insurance plans can be directed to the Pensions, Benefits, and Employee Health Programs Department. Questions regarding payroll premium deductions, eligibility and coverage dates, application procedures, or claims procedures can be directed to your pay specialist.

Section I - Basic Life Insurance

1. Eligibility and Effective Date of Coverage

Generally speaking, employees appointed on a full-time or a part-time basis (i.e., assigned to work more than 1/3 of the normally scheduled hours of work for his/her occupational group) are covered on a compulsory basis, as follows:

Appointment Status	Eligibility Date	Coverage Date
indeterminate period	from the date of appointment	from the date of appointment
term of more than 6 months	from the date of appointment	from the date of appointment
term of 6 months or less, and appointed to another term of less than 6 months	from the day following completion of 6 months continuous employment	from the day following completion of 6 months continuous employment
term of 6 months or less, and appointed for a term of another 6 months or more	from the date of the new appointment	from the date of the new appointment

Your insurance cannot become effective while you are not actively at work. If, for example, you are off sick on the day your insurance would otherwise become effective, your coverage will be postponed until you return to regular active duties.

2. Coverage

The amount of your Basic Life Insurance is equal to twice your annual earnings, adjusted to the next higher multiple of \$250, if that amount is not already a multiple thereof. For example, if your earnings were \$36,000, your coverage would be \$72,000; if your earnings were \$36,800, it would be \$73,750.

The amount of this insurance is revised immediately to reflect any changes in your earnings resulting from earnings-rate adjustments, merit increases and promotions. In the case of retroactive salary increases, coverage will change effective the first of the month following the month in which the change is authorised. Retroactive salary changes are not retroactive for insurance purposes. For example, a salary increase, retroactive to June 12, 1999, is authorised by the signing of a collective agreement on June 17, 2000. Basic Life Insurance earnings increases effective July 1, 2000.

The amount of Basic Life Insurance reduces following the date you attain age 61. It is reduced by 10% for each year following your 61st birthday. For example, if you are covered for \$60,000 at age 60 and your earnings do not change, you would be covered for \$54,000 at age 61, \$48,000 at age 62, \$42,000 at age 63 and so on. This yearly reduction will take effect on the April 1st or the October 1st following your 61st birthday, whichever date comes first.

If you remain hired with NAV CANADA beyond your 65th birthday, or if you retire with at least 2 years of service with NAV CANADA and with an immediate pension under the NAV CANADA Pension Plan, premiums for the first \$5,000 of your Basic Life Insurance will be paid by NAV CANADA. This lifetime premium payment is automatically provided when you reach age 65. This means that NAV CANADA will pay for the first \$5,000 of your Basic Life Insurance benefit from your 65th birthday until you die. However, you will remain responsible for paying your share of the costs for the insurance amount in excess of \$5,000.

If you die while still hired with NAV CANADA after you reach age 66, the minimum amount you would be covered for is the greater of \$5,000 or 1/3 of your adjusted annual earnings at the time of your death.

3. Premiums

Except for the first \$5,000 of coverage paid by NAV CANADA as described above, you contribute for as long as you are covered. The current premium rates are as follows:

Employee share	\$0.05 for every \$250 of adjusted annual earnings
Employer share	\$0.0045 for every \$250 of adjusted annual earnings

You should keep in mind that periodic changes are made to the insurance plans, which may include changes to monthly premium rates. These changes will be announced on each occasion through the Pensions, Benefits, and Employee Health Programs Department.

4. Extension of Coverage During Leave

If you are on a leave of absence, with or without pay, you will still contribute and be covered. Your pay specialist will tell you how to remit your contributions.

Your coverage will be continued, where applicable, during any paid leave.

5. Termination of Coverage

Your coverage may continue after you leave NAV CANADA. Your Pension Advisor will provide details on how you can continue Basic Life Insurance coverage when you leave NAV CANADA to you.

6. Beneficiaries

You may designate any of the following as your beneficiary (ies):

- your estate;
- any person;
- any charitable or benevolent organisation or institution; and
- any education or religious organisation or institution that is supported by donations.

Your pay specialist will supply you with the form to name a beneficiary (ies). The form must be signed, dated and submitted to your Pay Section.

You may, at any time, change your revocable beneficiary (ies). Your pay specialist will explain how to do this.

If you are a resident of Québec, the appointment of your spouse as your beneficiary (ies) is irrevocable (i.e., you cannot change this at a later time) unless you designate this choice as "revocable". Appointment of any other beneficiary (ies) is revocable.

If your beneficiary (ies) is (are) a minor(s), you should name a Trustee (Tutor in Québec).

7. Claims Procedures

7.1 Payment of Benefits

In the event of your death from any cause whatsoever, the amount of Basic Life Insurance in force on your life at that time will be paid to your beneficiary (ies) or, if your beneficiary (ies) predeceases you or you have not named any, to your estate.

Under certain circumstances, all or a portion of the benefit can be applied directly against the expenses for the maintenance, medical care or funeral of a participant. For example, part of the Basic Life benefit could be used to pay a funeral bill, or to reimburse a person or group who has already paid the funeral expenses. The expenses must be "reasonable" as determined by the Great-West Life. Please note that this provision is intended primarily to cover difficult situations, such as where there is no estate, or one with insufficient assets, or where a long delay in settling the estate is expected.

7.2 Claims Submission

Your beneficiary (ies) must complete and submit a Life Claim Report and attach or submit acceptable proof of death (e.g., the Provincial Death Certificate or a copy of the Funeral Director's Certificate). Forms are available from the Pensions, Benefits, and Employee Health Programs Department who will submit them to the Great-West Life.

The Contract Number (139100), your name and the nature of the claim should be quoted in order to speed handling of the claim.

Section II - Long-term Disability

1. Eligibility and Effective Date of Coverage

Generally speaking, employees appointed on a full-time or a part-time basis (i.e., assigned to work more than 1/3 of the normally scheduled hours of work for his/her occupational group) are covered on a compulsory basis, as described below:

Appointment Status	Eligibility Date	Coverage Date
indeterminate period	from the date of appointment	from the date of appointment
term of more than 6 months	from the date of appointment	from the date of appointment
term of 6 months or less, and appointed to another term of less than 6 months	from the day following completion of 6 months continuous employment	from the day following completion of 6 months continuous employment
term of 6 months or less, and appointed for a term of another 6 months or more	from the date of the new appointment	from the date of the new appointment

Your insurance cannot become effective while you are not actively at work. If, for example, you are off sick on the day your insurance would otherwise become effective, your insurance will be postponed until you return to regular active duties.

2. Coverage

2.1 General

Long-term Disability (LTD) Insurance provides income-replacement benefits equal to 70% of your insured earnings during periods of total disability.

Under the LTD plan, you are eligible for benefits for up to 24 months if you become totally disabled for the essential functions of your own regular job. If, at the end of this 24-month period, you are totally disabled for any reasonably commensurate occupation for which you are qualified by training, education or experience, your benefits will be continued. A "commensurate occupation" means one for which the rate of pay is at least two-thirds of the current rate of your former job. Thus, if your disability prevents you from doing your own job and, later, any commensurate one, your LTD benefits will continue as long as you remain totally disabled, but not, in any case, beyond your 65th birthday.

The only other circumstance in which benefits may be paid for a time beyond 24 months is where you are engaged in a Rehabilitation Plan approved by the Great-West Life (see Earnings from Rehabilitation Plans, in Section 2.5 below).

While you are receiving benefits, you must be under the active care of a licensed physician and following a course of treatment satisfactory to the Great-West Life. In general, you need not be confined to a hospital.

You are not eligible for benefits if your disability:

- is related to a condition that existed before you became insured;

This restriction is lifted for all unionised employees, if you have been actively at work for a continuous period of 13 weeks (absences up to 2 days will not affect this requirement) or have not had medical care for disease or injury for a continuous period of 90 days ending on or after the effective date of your insurance under this benefit, or if you become totally disabled more than 1 year after the effective date of your insurance under this benefit.

If you are laid off and re-appointed within one year under a work force adjustment program, you may use any period of work before the lay-off toward fulfilling the one-year condition.

- arises from commission of a felony, insurrection or voluntary participation in a riot, or injury or disease suffered on active duty with any armed force; or
- results from an act of war.

This restriction does not apply to persons who become totally disabled as a result of such an act to which they have been exposed by the performance of duties outside Canada at NAV CANADA'S direction.

If you become totally disabled, you should consult your pay specialist, even if you think you may not qualify for benefits. If you are on a leave without pay, no benefits are payable during the scheduled duration of a leave of absence.

Your benefits begin after an "elimination period", that is equal to your period of benefits under the Disability Income Security Programme or the expiration of your sick leave credits, whichever is the later date. Please consult your collective agreement in order to determine which type of benefit applies to you.

If you are in receipt of benefits under the Disability Income Security Programme when you retire, or if you are using sick leave credits when you retire, the unused period of Disability Income Security, or sick leave credits, will still be counted in determining the date your LTD benefits begin.

2.2 Amount of Benefit

If you become totally disabled, your gross annual benefit will be 70% of your insured annual adjusted earnings (which for part-time members is based on assigned hours of work). The adjusted earnings are equal to the annual earnings taken to the next higher multiple of \$250, if that amount is not already a multiple thereof. Payments are made monthly, beginning on the date of completion of your elimination period. The benefit will be reduced by 100% of any other disability income that you receive for the same disability or a subsequent one. An explanation of what is considered as "Other Disability Income" is given below.

Your net benefit (i.e., the amount payable to you after other disability income has been deducted) will be subject to an annual increase related to increases in the cost of living, to a maximum of 3%. Any retroactive salary increase approved after the effective date of commencement of your benefits affects your insured earnings and benefit level only when the date of the increase precedes the date your LTD benefits began. For example, a retroactive salary increase approved in April, with effect from February 10th would only be counted in calculating your benefit if your LTD benefits commenced effective February 11th or later.

2.3 Other Disability Income

The following are the main examples of what is counted as "*other disability income*":

- benefits received under the Public Service Superannuation Act (PSSA) and the NAV CANADA Pension Plan;
- disability benefits under the Canada Pension Plan (CPP) or the Québec Pension Plan (QPP), excluding benefits payable to, or on behalf of, your dependants as a result of your disability;
- benefits under the applicable Workers' Compensation Act, or a plan of the federal or any other government providing similar benefits;
- disability benefits paid or available under another group insurance plan, or under a policy issued to you as a result of your membership in an employee union or association; and
- in general, disability insurance benefits under the legislation of any government, for example, income replacement benefits under the Québec Auto Insurance Plan.

Other disability income also includes benefits that, in the Great-West Life's opinion, you would be entitled to receive if you made application for them. For example, if the medical evidence suggests to the Great-West Life that you would be eligible for benefits under the CPP/QPP but have not applied for them, the Great-West Life will ask you to apply for CPP/QPP and to sign a form through which you agree to reimburse LTD benefits which would have been offset should your claim for CPP/QPP be approved. You should note, however, that if your claim for CPP/QPP benefits is denied and the Great-West Life considers that you may have grounds for a successful appeal, they will request that you submit an appeal. They will not offset your LTD benefits until confirmation regarding the appeal is received from CPP/QPP.

Where a benefit becomes payable to you or on your behalf and you have a legal right to recover damages from a third party (any individual or organisation), the Great-West Life will be entitled to reimbursement for any amount you recover from the third party, to the extent of the benefits paid or payable. You will be required to sign a subrogation agreement in this regard, prior to commencement of benefit payments.

Following notification to the Great-West Life of payment by a third party of any judgement or settlement, further disability benefit payments under the Long-term Disability Insurance plan will cease until the Great-West Life has been reimbursed the amount set out in the subrogation agreement. If a lump-sum payment is made under judgement or settlement for loss of future income, no further disability benefits will be paid under the Long-term Disability Insurance Plan until such time as the sum of the benefit payments otherwise payable equals the amount of such lump-sum.

The following do not count as other disability income:

- increases related to the cost of living under CPP or QPP, or the cost of living increases by which benefits under the PSSA or the NAV CANADA Pension Plan are increased;
- returns of pension contributions based on less than 2 years of pensionable service under the PSSA, or 2 years of membership in the NAV CANADA Pension Plan, where no pension entitlement is available;
- benefits under a purely private and personal insurance policy, or a policy issued as a result of membership in a professional association not restricted to NAV CANADA;
- severance pay; and
- early departure/retirement incentives.

2.4 Example of LTD Monthly Benefit Calculation

Annual earnings at end of elimination period	\$47,925
Insured adjusted earnings (earnings taken to next higher multiple of \$250)	\$48,000
Gross annual LTD benefit (\$48,000 x 70%)	\$33,600
Other annual disability income:	
Pension Plan	\$14,000
CPP	<u>+\$8,000</u>
Total of other disability income	<u>\$22,000</u>
Gross annual LTD benefit	\$33,600
Less: Total of other disability income (annual)	<u>-\$22,000</u>
Net annual LTD benefit	\$11,600
Amount of monthly LTD payments (\$11,600 ÷ 12)	\$967

If the cost of living continued to rise by at least 3% per year, your net monthly LTD benefit of \$967.00 would be increased by 3% to \$996.01 on January 1st following the date your benefits commenced.

At the same time, your PSSA, NAV CANADA Pension Plan and CPP/QPP benefits would also be increased in relation to rises in the cost of living. Any increase you received under those plans would not be offset from your LTD benefit. You would receive the full benefit of escalation under the other plans.

On January 1st of each subsequent year, your LTD benefit would be further increased in accordance with increases in the cost of living, to a maximum of 3% annually. Again, you would receive the full benefit of any higher escalation factors that were applied to your PSSA, NAV CANADA Pension Plan and CPP/QPP benefits.

2.5 Earnings from Rehabilitation Plan

While receiving benefits, you may engage in a Rehabilitation Plan, which means a program or vocation training or a period of work for the purpose of rehabilitation, either of which is approved in writing by the Great-West Life. Depending on the circumstance, you may be able to engage in such a Rehabilitation Plan for up to 24 months without losing your qualification for benefits. However, your total income while working, together with any benefits you are receiving under the Long-term Disability Insurance Plan, must not exceed your pay before you became disabled.

Please note that your benefits would be reduced by 100% of any earnings from employment not approved by the Great-West Life as rehabilitative. Also, the Great-West Life may withhold or discontinue your benefits if you do not make a reasonable effort to participate or co-operate in a Rehabilitation Plan that it has recommended or approved.

2.6 Income Tax

If you become totally disabled and qualify for benefits under the Long-term Disability Insurance Plan, your benefits will be subject to income tax. After the end of each year, the Great-West Life will send you a form indicating the total amount of benefits paid to you. The Great-West Life does not automatically deduct taxes at source except in the case of provincial taxes payable by Québec residents, which must, by law, be deducted at source.

If you wish, however, the Great-West Life will deduct taxes at source based on the information you provide on your exemptions. If you are not a Québec resident and you prefer to look after your taxes yourself, you are free to do so. In this case, you should contact your District Taxation Office for information as soon as benefits commence, so that you will not be faced later with an unexpected substantial tax adjustment.

The monthly premiums you pay while you are hired are not tax deductible from earnings. If you do become eligible for benefits, however, the total amount of the premiums you have paid from the time you became a member of the plan may be deducted for tax purposes from the amount of your disability income from the plan. If the total amount of premiums you have paid exceeds the amount of benefits you receive during the first taxation year in which your benefits commence, the excess amount can be carried over to be applied in the following year. Again, you should consult your District Taxation Office for details if you become totally disabled. Your pay specialist will assist you, upon request, in determining the amount of premiums you have paid, should the need arise.

2.7 Recurrence of Disability

If you receive disability benefits, recover, and again become totally disabled, you need not complete another elimination period unless you were back at work on a regular basis for at least:

- one (1) month, if the 2 periods of disability are due to unrelated causes;
- six (6) months, if the 2 periods of disability are due to related causes; and
- twelve (12) months, if the 2 periods of disability are due to the same cause.

If a period of total disability is considered under this provision to be a continuation of a previous period of total disability, the amount of benefits payable will be the same as you were receiving before you returned to work.

3. Premiums

3.1 Amount of Premiums

The premium rates, effective January 1st, 2000, are as follows:

Employee share	\$0.162 per \$1000 of adjusted annual earnings
Employer share	\$1.728 per \$1000 of adjusted annual earnings

You should keep in mind that periodic changes are made to the insurance plans, which may include changes to monthly premium rates. These changes will be announced on each occasion through the Pensions, Benefits, and Employee Health Programs Department.

3.2 Waiver of Premium

If you become totally disabled by bodily injury or disease to the point where you qualify for LTD benefits, you will not have to pay further premiums for LTD while you are receiving a monthly LTD benefit, on sick leave without pay during the "elimination period", or while you are on rehabilitative employment approved by the Great-West Life. These benefits will be continued in force without payment of further premiums from the date your remuneration ceases until your recovery, death or 65th birthday, whichever comes first. This provision is subject to proof of total disability, initially and from time to time as required by the Great-West Life.

4. Extension of Coverage During Leave

If you go on authorised leave without pay, coverage paid by NAV CANADA will be extended to you for the total period of absence. Please contact your pay specialist for further details.

Your coverage will be continued, where applicable, during any paid leave.

5. Termination of Coverage

Long-term Disability Insurance ceases on the day you reach age 65 or, if earlier, when you retire.

If the group policy were to terminate for any reason after your disability commenced, any benefits for which you may be eligible will be paid and will continue to be paid by the Great-West Life as long as you remain totally disabled from the same cause.

6. Claims Procedures

6.1 Claims Submission

If you become totally disabled and you think your disability will last longer than the "elimination period", described in paragraph 2 above, you should notify your pay specialist as soon as possible. S/he will provide you with a claim form and the form entitled "Attending Physician's Initial Statement - Long Term Disability" for your doctor to complete.

It will be your responsibility to complete the claim form and to arrange for the completion of the Attending Physician's Statement. It is important for both you and your doctor to complete these statements as clearly and completely as possible. Claims for benefits are adjudicated by the Great-West Life on the basis of all, and only, the objective medical evidence provided on your condition.

Accordingly, you should ask your doctor to provide a full, well-documented report that clearly shows the objective medical evidence supporting his/her diagnosis and prognosis. If more than one doctor is involved in the assessment or treatment of your disabling condition, you should ask them all to supply the Great-West Life with full medical reports. The onus is ultimately on you to provide the Great-West Life with sufficient medical proof of total disability. Please note that any omissions or unclear statements could result in a delay in settling your claim.

You should return the completed forms to your pay specialist, who is responsible for inserting additional information and passing the claim on for processing. (If you wish, the attending Physician's Statement can be detached and mailed directly to the Great-West Life. It is your responsibility to ensure that the medical report is completed by your doctor in a timely manner and reaches the Great-West Life without delay.) All of this should be done within 90 days of the date you become totally disabled.

The Great-West Life has the right to request additional medical information from your doctors, or to arrange for your medical examinations by independent specialists as often as may be reasonably required. Independent medical consultants often provide the only objective way for the Great-West Life to assess, or to monitor the cause of a disability, to ensure that benefits are not paid to persons who are not eligible or who have recovered to the point where they no longer qualify.

6.2 Payment of Claims

Monthly payments will begin one month after the elimination period has expired as long as the required forms have been submitted and the claim has been approved. Benefits payments will continue as long as the medical information required is provided, supporting the continuance of disability, up to the maximum benefit period.

Submit Long-term Disability claims to the Great-West Life Assurance Company at the location indicated below. The telephone number for claims inquiries is also listed.

Great-West Life Assurance Company
Ottawa Disability Management Services Office
11 Holland Avenue, Suite 300

Ottawa, Ontario
K1Y 4W4

(613) 761-3940 or
1-800-283-5375

6.3 Claims Appeal Process

Where you do not agree with a decision made by the Great-West Life and wish a review of your claim, you should contact the Pensions, Benefits, and Employee Health Programs Department.

Section III - Health Care Plan

In broad terms, the Health Care Plan is designed to provide employees and their dependants with 2 types of coverage. These types are Supplementary and Comprehensive coverage and are described below in Section 2.1.

1. Eligibility and Effective Date of Coverage

1.1 Employee Eligibility

Generally speaking, both full-time and part-time employees are eligible to join the Health Care Plan on a voluntary basis, as described below:

Appointment Status	Eligibility Date	Coverage Date		Example
		Application received within 60 days of eligibility date	Application received more than 60 days after eligibility date	
indeterminate period	from the date of appointment	the first day of the month following the month in which the application is received	the first day of the fourth month after the date the application is received	Appointed: 12/06/00 Eligible: 12/06/00 App. rec'd: 12/07/00 Coverage: 01/08/00 App rec'd: 14/08/00 Coverage: 01/12/00
term of more than 6 months	from the date of appointment	the first day of the month following the month in which the application is received	the first of the fourth month after the date the application is received	Appointed: 12/06/00 Eligible: 12/06/00 App. rec'd: 12/07/00 Coverage: 01/08/00 App. rec'd: 14/08/00 Coverage: 01/12/00
term of 6 months or less, and appointed to another term of less than 6 months	from the day following completion of 6 months continuous employment	the first day of the month following the month in which the application is received	the first of the fourth month after the date the application is received	Term A: 12/06/00 to 08/09/00 Term B: 09/09/00 to 28/02/01 Eligibility: 12/12/00 App. rec'd: 08/01/01 Coverage: 01/02/01 App. rec'd: 19/03/01 Coverage: 01/07/01
term of 6 months or less, and appointed for a term of another 6 months or more	from the date of the new appointment	the first day of the month following the month in which the application is received	the first of the fourth month after the date the application is received	Term A: 12/06/00 to 08/09/00 Term B: 09/09/00 to 30/04/01 Eligibility: 09/09/00 App. rec'd: 26/10/00 Coverage: 01/11/00 App. rec'd: 22/01/01 Coverage: 01/05/01

If you do not apply for coverage within 60 days of being eligible, or if you do not apply to upgrade your coverage from "single" to "family" within 60 days of acquiring a new dependant (see 1.2 below), the coverage will only take effect after a 3-month waiting period (i.e., on the first day of the fourth month following receipt of your application by your pay specialist).

Since Comprehensive Health Care coverage is compulsory for employees posted outside Canada, your coverage and that of any eligible dependants begins automatically on the date your provincial health coverage expires. However, you must submit an application to your pay specialist prior to residing abroad.

Your insurance cannot become effective while you are not actively at work. If, for example, you are off sick on the day your insurance would otherwise become effective, your insurance will be postponed until you return to regular active duties.

1.2 Dependants' Eligibility

Your dependants become eligible for coverage when you become eligible or, if acquired later, upon becoming your dependant. If you acquire a new dependant (i.e., a spouse or child), you should inform your pay specialist as soon as possible. If an application is required to cover that dependant (i.e., to increase your coverage from "single" to "family"), the application form must be received within 60 days from the date the dependant became eligible in order for coverage to become effective from that date.

You must be covered in order for your dependants to be covered. A person may not be covered for the Health Care Plan as a dependant of more than one employee; or both as an employee and as a dependant. Your eligible dependants include:

- your legal spouse of either gender, or the person who has lived with you as your spouse in a permanent, exclusive relationship for a continuous period of at least one year and continues to live with you as such; and
- unmarried children of you or your spouse, including adopted children, stepchildren, foster children, or children for whom you or your spouse is the legal guardian, and who are:
 - ⇒ under 21 years of age;
 - ⇒ age 21 or older and depend on you for support because of a mental or physical disability, provided they become disabled before age 21. (This description should apply to your child on the date you become eligible for coverage under the Health Care Plan, otherwise the child has to have been covered under the Health Care Plan immediately before his or her 21st birthday. If the child becomes disabled after reaching the age of 21, s/he must have been covered as a student at the time the disability began.); and
 - ⇒ if older, while full-time students enrolled in a school or a university up to age 25 (26 in Québec).

1.3 Benefits Card

Once you become covered you will receive a Benefits Card. This card will contain your name, your level of coverage, and the Member ID that has been assigned to you to identify you to Sun Life when you file your claims. You must record your Member ID on all claims that you submit for yourself and your eligible dependants and all correspondence with Sun Life.

Should you lose your Benefits Card, please contact your pay specialist to obtain a replacement card.

2. Coverage

2.1 General

There are two types of coverage. They are:

Supplementary Coverage: This coverage is intended for eligible employees who are Canadian residents and are covered under a provincial health plan. In general, the Health Care Plan supplements the coverage provided under the provincial health plan in your province of residence. This coverage consists of the Extended Health Care Benefit and the Hospital Benefit (both described in detail in this section). The Basic Health Care Benefit and the Hospital Expense (Outside Canada) Benefit are not available to persons in this category.

Comprehensive Coverage: This coverage is intended for eligible employees who are residing outside Canada and are not covered under a provincial health plan. This coverage consists of the Basic Health Care Benefit, the Extended Health Care Benefit, the Hospital Benefit, and the Hospital Expense (Outside Canada) Benefit. If your spouse and any eligible children are residing with you outside Canada, you are also required to obtain Comprehensive Coverage for those dependants.

Coverage is also available, on a voluntary basis, for certain persons (other than a spouse or child) who reside with you and are financially dependent upon you. Further details are available from your pay specialist.

2.2 Description of Benefits

2.2.1 Extended Health Care Benefit

The purpose of this benefit is to provide coverage, subject to conditions listed below, for specific services and products that are not usually covered under the provincial health plans or, alternatively, in the case of members resident outside Canada, for specific services and products that are not covered under the Basic Health Care Benefit.

The Extended Health Care Benefit comprises the following benefits, which are described in b) to g) below:

- Drug Benefit;
- Vision Care Benefit;
- Health Practitioners Benefit;
- Oral Surgical and Accidental Dental Benefit;
- Miscellaneous Expense Benefit; and
- Out-of-Province Benefit.

a) *Conditions*

i) Reasonable and Customary Charges

When you incur charges for a particular eligible service or product, the plan covers only those amounts considered "reasonable and customary". Sun Life will determine what the general level of charges for any specific service or product is in the locale where the expense is incurred. Published fee guides of associations of practitioners will be consulted for that purpose. Any portion of an expense in excess of that "reasonable and customary" amount will not be covered.

ii) Limits on Eligible Expenses

Some of the eligible expenses are subject to specific limits. These limits are set out either in the explanation of the benefits in section 2.2.1 b) to g), or in the Table of Health Care Maximum Eligible Expenses (see Appendix A). Any expenses you incur that exceed those limits will not be covered. Changes to these amounts will be announced through the Pensions, Benefits, and Employee Health Programs Department, and should be noted for future reference.

iii) Deductible Amount

For each calendar year, there is a minimum deductible amount. Only the eligible expenses incurred by you during the year that exceed that deductible amount are eligible for reimbursement under the Extended Health Care Benefit.

The annual deductible amount is \$25 per person. If you have "family" coverage, but only one member of your family incurs eligible expenses in a calendar year, the annual deductible of \$25 will apply to those expenses. Where eligible expenses are incurred in a calendar year by more than one member of a covered family, then the combined deductible amount that must be exceeded for all members of that family will be limited to \$40 for that calendar year.

iv) Co-insurance

Except where otherwise stated, such as under the Travel Benefit, the Extended Health Care Benefit will reimburse you 80% of the reasonable and customary charges you have incurred for a particular covered service or product above the

annual deductible amount. This is subject to limits that may be in place on the amount of eligible expenses covered for that product or service. The remaining 20% of such eligible expenses must be paid by you and is referred to as the co-insurance.

v) *Pre-determination of Benefits*

When the estimated cost of treatment will exceed \$300, you are strongly urged to submit a treatment plan to Sun Life before proceeding with these services. Upon receipt of a treatment plan, Sun Life will tell you the benefits payable under the Health Care Plan for the services that are proposed. Consequently, it is in your own best interest to determine what will be paid before the work is begun.

b) **Drug Benefit**

i) *Eligible Expenses*

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician:

- *drugs*, including oral contraceptives, that legally require a prescription and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription;
- *life-sustaining drugs*, that may not legally require a prescription and are identified in the Therapeutic Guide section of the current Compendium of Pharmaceuticals and Specialties under the following headings:
 - ⇒ anti-anginal agents;
 - ⇒ antiparkinsonism agents;
 - ⇒ bronchodilators;
 - ⇒ antihyperlipidemic agents;
 - ⇒ hyperthyroidism therapy;
 - ⇒ parasympathomimetic agents;
 - ⇒ tuberculosis therapy;
 - ⇒ anticholinergic preparations;
 - ⇒ anti-arrhythmic agents;
 - ⇒ glaucoma therapy;
 - ⇒ insulin preparations;
 - ⇒ oral fibrinolytic agents;
 - ⇒ potassium replacement therapy; and
 - ⇒ topical enzymatic debriding agents;
- *drugs* that are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as not legally requiring a prescription but that are only available for purchase at any accredited pharmacy and that, in Sun Life's opinion, have a known therapeutic value;
- *replacement therapeutic nutrients* prescribed by an accredited medical specialist for the treatment of an injury or disease excluding allergies or aesthetic ailments, provided that there is no other nutritional alternative to support the life of the member or covered dependant;
- *injectable drugs*, including allergy serums administered by injection;
- *compounded prescriptions*, regardless of their active ingredients;
- *hypodermic needles, syringes, and chemical diagnostic aids* for treatment of diabetes except that needles and syringes are not eligible for the 36-month period following the date of purchase of an insulin jet-injector device;
- *vitamins and minerals* that are prescribed for the treatment of a chronic disease, when in accordance with customary practice of medicine, the use of such products are proven to have therapeutic value and no other alternatives are available to the patient;
- *drug-delivery devices* to deliver asthma medication that are integral to the product, as approved by Sun Life;
- *aerochambers* with masks for the delivery of asthma medication to children under 6 years of age; and

- any *smoking cessation aids* which require a prescription, limited to the maximum eligible expense specified in Appendix A.

ii) Exclusions

Note the exclusions and limitations set out in Appendix B.

c) Vision Care Benefit

i) Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense:

- eye examinations performed by a licensed optometrist, limited to one examination in a 2-calendar year period; and
- eyeglasses and contact lenses that are necessary for the correction of vision and are prescribed by an ophthalmologist or licensed optometrist, and repairs to them, limited to the maximum eligible expense specified in Appendix A.

To simplify the administration of the 24-month limitation on eyeglasses and contact lenses, all members of the Health Care Plan, and their dependants, will have the same 2-year period in which to claim up to the stated maximum for the purchase cost of eyeglasses and contact lenses.

Example: You may claim up to \$200 on the purchase of eyeglasses and contact lenses for yourself and/or your dependants during the 2-year period from January 1, 1999 to December 31, 2000. Once you have claimed the maximum expense that 2-year period, (which is \$200 for the 2-year period January 1, 1999 to December 31, 2000), you are ineligible to claim further expenses for eyeglasses or contact lenses until the new 2-year period commences, i.e., from January 1, 2001 to December 31, 2002.

There is no limit on the initial purchase of eyeglasses or contact lenses that are required as the direct result of surgery or an accident, if they are purchased within 6 months of such surgery or accident. This is identified as a separate eligible expense. This time limit may be extended if Sun Life determines the purchase could not have been made within the time frame specified.

The purchase of artificial eyes, and replacements thereof, is also an eligible expense, but not within:

- 60 months of the last purchase in the case of a member or dependant over 21 years of age; or
- 12 months of the last purchase in the case of a dependant 21 years of age or less.

ii) Exclusions

Note the exclusions and limitations set out in Appendix B.

d) Health Practitioners Benefit

For definitions of chiropractor/podiatrist, chiropractor, electrologist, naturopath, osteopath, physician, physiotherapist, psychologist, registered massage therapist and speech language pathologist, please see the Glossary in Appendix C.

i) Eligible Expenses

To be eligible, the services of these practitioners must be medically necessary for the treatment of disease or injury. Eligible expenses for the services of practitioners include only those services that are within his or her area of expertise and require the skills and qualifications of such a practitioner. All practitioners must be licensed, registered, or certified through the respective provincial licensing body or professional organisation, as the case may be.

Eligible expenses are the reasonable and customary charges for:

- the services of the following practitioners, limited to the maximum eligible expense specified in Appendix A for each practitioner:
 - ⇒ a physiotherapist* (no maximum);
 - ⇒ a registered massage therapist;
 - ⇒ a speech language pathologist*;

- ⇒ a psychologist*;
 - ⇒ a chiropractor;
 - ⇒ an osteopath;
 - ⇒ a naturopath;
 - ⇒ a podiatrist, or chiropodist; and
 - ⇒ an electrologist**; and
 - utilisation fees for paramedical services that are imposed by the government under the provincial health plan in the person's province of residence, where law permits a person to be reimbursed for such charges.
- * requires prescription of a physician.
- ** services of an electrologist require a psychiatrist's or psychologist's prescription; reimbursement is limited to treatment for the removal of excessive hair from exposed areas of the face and neck, when the patient suffers from severe emotional trauma as a result of this condition.

ii) Exclusions

Note the exclusions and limitations set out in Appendix B.

e) Oral Surgical and Accidental Dental Benefit

For definitions of dentist and fee guide, please see the Glossary in Appendix C.

i) Eligible Expenses

The Health Care Plan covers only expenses for specified oral surgical procedures, and for certain dental treatment required as the result of an accident.

ii) Oral Surgical Procedures

Eligible expenses means reasonable and customary charges for the following oral surgical procedures performed by a dentist:

- cysts, lesions, abscesses;
 - ⇒ biopsy;
 - ◇ soft-tissue lesion;
 - ◇ incision;
 - ◇ excision;
 - ◇ hard-tissue lesion;
 - ⇒ excision of cysts;
 - ⇒ excision of benign lesion;
 - ⇒ excision of ranula;
 - ⇒ incision and drainage;
 - ◇ intra oral - soft tissue;
 - ◇ intra osseous - (into bone);
 - ⇒ periodontal abscess;
 - ◇ incision and drainage;
- gingival and alveolar procedures;
 - ⇒ alveoplasty;
 - ⇒ flap approach with curettage;
 - ⇒ flap approach with osteoplasty;
 - ⇒ flap approach with curettage and osteoplasty;
 - ⇒ gingival curettage;
 - ⇒ gingivectomy with or without curettage;
 - ⇒ gingivoplasty;
- removal of teeth or roots;
 - ⇒ removal of impacted teeth;
 - ⇒ removal of root or foreign body from max. antrum;
 - ⇒ root resection - (apiectomy or apicoectomy);
 - ◇ anterior teeth;

- ◇ bicuspid;
 - ◇ molars;
- fractures and dislocations;
 - ⇒ dislocation - temporomandibular joint (or jaw);
 - ◇ closed reduction;
 - ◇ open reduction;
 - ⇒ fractures - mandible;
 - ◇ no reduction;
 - ◇ closed reduction;
 - ◇ open reduction;
 - ⇒ fractures - maxillar or malar;
 - ◇ no reduction;
 - ◇ closed reduction;
 - ◇ open reduction;
 - ◇ open reduction (complicated);
- other procedures;
 - ⇒ avulsion of nerve - supra or infra-orbital;
 - ⇒ frenectomy - labial or buccal (lip or cheek);
 - ⇒ lingual (tongue);
 - ⇒ repair of antro-oral fistula;
 - ⇒ sialolithotomy - simple;
 - ⇒ sialolithotomy - complicated;
 - ⇒ sulcus deepening, ridge reconstruction;
 - ⇒ treatment of traumatic injuries;
 - ◇ repair of soft tissue lacerations;
 - ◇ debridement, repair, suturing;
 - ⇒ torus (bone biopsy);

iii) Accidental Injury

The services of a dentist/dental surgeon and the charges for braces and splints are eligible expenses, when required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by an external, violent and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing and eating provided the treatment occurred within 12 months following the accident or, in the case of a child under 17 years of age, before the child attained 18 years of age. This time limit may be extended if, in Sun Life's opinion, the treatment could not have been rendered within the time frame specified.

iv) Exclusions

Note the exclusions and limitations set out in Appendix B.

f) Miscellaneous Expense Benefit

For definitions of hospital and physician, please see the Glossary in Appendix C.

i) Eligible Expenses

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

Eligible expenses are the reasonable and customary charges for the expenses listed below:

- *physician's services*, where such services are not eligible for reimbursement under your provincial health plan, but where such services would be eligible for reimbursement under one or more provincial health plans;
- *services of a nurse*, providing private-duty nursing services where such services are rendered in the patient's private residence, subject to the maximum eligible expenses specified in Appendix A. To be

eligible, the expenses must be medically necessary for the treatment of disease or injury, and be prescribed by a physician;

- *electrolysis treatments*, performed by a physician or a licensed electrologist, provided these are prescribed by a psychiatrist or psychologist; reimbursement is limited to treatment for the removal of excessive hair from exposed areas of the face and neck, when the patient suffers from severe emotional trauma as a result of this condition. Reimbursement is limited to the maximum eligible expenses specified in Appendix A;
- *acupuncture treatments* performed by a physician;
- *the initial purchase of eyeglasses, contact lenses or hearing aids, if required as the direct result of surgery or an accident*, where the purchase is made within 6 months of such surgery or accident;
- *hearing aids prescribed by an ear, nose, and throat specialist and repairs to them*, excluding batteries, limited to the maximum eligible expense specified in Appendix A;
- *licensed ground-ambulance service* to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation (except for eligible expenses payable for medical evacuation under the Travel Benefit, see Section 2.2.1 g));
- *emergency air-ambulance service* to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation (except for eligible expenses payable for medical evacuation under the Travel Benefit, see Section 2.2.1 g));
- *orthopaedic shoes* that are an integral part of a brace or are specifically constructed for the patient, including modifications to such shoes, provided the shoes or modification are prescribed in writing by a physician or a podiatrist, subject to a maximum total eligible expense in any one calendar year of the lesser of:
 - ⇒ the total charges, less the average cost of regular footwear as determined by Sun Life; or
 - ⇒ the amount specified in Appendix A;
- *orthotics*, limited to one pair in a calendar year;
- *trusses, crutches, splints, cast and cervical collars*;
- *braces* that contain either metal or hard plastic, excluding dental braces and braces used primarily for athletic use;
- *elasticised support stockings and elasticised apparel for burn victims*, manufactured to individual patient specifications, or having a minimum compression of 30 millimeters;
- *bandages and surgical dressings* required for the treatment of an open wound or ulcer;
- *orthopaedic brassieres*, limited to the maximum eligible expense specified in Appendix A;
- *breast prosthesis* following mastectomy, and replacement, but not within 24 months of the last purchase;
- *wigs*, when the patient is suffering from total hair loss as the result of a disease or illness, limited to the maximum eligible expense specified in Appendix A;
- *colostomy, ileostomy and tracheostomy supplies, catheters and drainage bags* for incontinent, paraplegic or quadriplegic patients;
- *temporary artificial limbs*;
- *artificial eyes, permanent artificial limbs* to replace temporary artificial limbs, and replacements thereof, but not within:
 - ⇒ 60 months of the last purchase in the case of a member or dependant over 21 years of age; or
 - ⇒ 12 months of the last purchase in the case of a dependant 21 years of age or less,
 unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis at an earlier date;
- *oxygen* and its administration;
- *insulin pumps and associated equipment* for insulin-dependant diabetics, when prescribed for a patient by a physician associated with a recognised centre for the treatment of diabetes at a university teaching centre, excluding repair or replacement during the 60-month period following the date of purchase of such equipment;
- *blood-glucose monitors* for insulin-dependant diabetics, and for non-insulin-dependant diabetics if legally blind or colour blind, excluding repair or replacement during the 60-month period following the date of purchase of such equipment;
- *rental or purchase, at Sun Life's option, of durable equipment* manufactured specifically for medical use that is required for temporary and therapeutic use in the patient's private residence and is approved by Sun

Life. Eligible durable equipment includes, but is not limited to, items such as walkers, hospital beds, apnea monitors and alarm systems for enuretic patients. (Reimbursement will be limited to the cost of non-motorised equipment unless medically proven that the patient requires motorised equipment);

- *rental or purchase*, at Sun Life's option, of a *wheelchair* required for therapeutic use in the patient's private residence. Reimbursement will be limited to the cost of non-motorised equipment unless medically proven that the patient requires motorised equipment. *Repairs and replacement of a purchased wheelchair* are eligible expenses, but not within 60 months of the last purchase of a wheelchair; and
- *insulin jet-injector device* for insulin-dependant diabetics, limited to the maximum eligible expense specified in Appendix A.

ii) Exclusions

Note the exclusions and limitations set out in Appendix B.

g) Out-of-Province Benefit

i) General

If you live in Canada, certain other expenses as described below are eligible where they are incurred outside your province of residence, either in another province or outside Canada, and where those expenses exceed the amount covered under your provincial health plan. Reimbursement may be made only if such coverage is not expressly prohibited by law, and is subject to the limits set out in Appendix A.

ii) Travel Benefit

In addition to the Extended Health Care benefits, certain expenses are also eligible (up to the limit set out in Appendix A) and are reimbursed at 100% with no annual deductible, when they are incurred for emergency treatment of an injury or disease suffered while travelling outside the province of residence, and where such treatment commenced not more than 40 days from your date of departure from the province of residence or while you were on official travel status (where treatment continues beyond the 40-day period, related expenses will be covered).

The Travel Benefit covers expenses for:

- public-ward accommodation and auxiliary hospital services in a general hospital;
- the services of a physician; and
- out-patient services in a hospital.

iii) Emergency Travel Assistance Benefit

A 24-hour "help-line" service is available, that you may call to obtain assistance for:

- one-way economy air fare for the patient, as well as for a professional attendant to transport the patient to the province of residence when medically required;
- medical evacuation, which may involve an ambulance service, when suitable care, as determined by Sun Life, is not available in the area where the emergency occurred;
- family assistance, such as reimbursement for the cost of the return of dependant children to Canada, subject to certain limits;
- transportation arrangements to the nearest hospital that provides the appropriate care, or back to Canada;
- medical referrals, consultation and monitoring;
- legal referrals;
- a telephone interpretation service;
- a message service for family and business associates (messages are held for up to 15 days); and
- advance payment on behalf of the member and covered dependants for hospital and medical expenses.

iv) Referral Benefit

The following expenses are eligible (up to the limit set out in Appendix A) and are reimbursed at 80% after the annual deductible is met, when the treatment or services are not offered in the province of residence and are incurred following written referral by the attending physician in your province of residence:

- public-ward accommodation and auxiliary hospital services in a general hospital;

- the services of a physician or surgeon; and
- out-patient services in a hospital.

v) *Exclusions*

Note the exclusions and limitations set out in Appendix B.

2.2.2 Basic Health Care Benefit

This benefit is applicable only to those employees who are eligible to join the Health Care Plan, and who reside outside Canada and are not covered under a provincial health plan. This benefit provides reimbursement for reasonable and customary charges for those health care expenses (excluding hospital services) that are covered under the provincial health plan of the province of Ontario to the maximum specified in Appendix A. The co-payment and the deductible amount do not apply under this benefit.

a) Eligible Expenses

Some of the more significant covered services are:

- a physician's services including:
 - ⇒ a physician's services in your home, the physician's offices, or in a hospital;
 - ⇒ diagnosis and treatment of illness and injury;
 - ⇒ one annual health examination;
 - ⇒ treatment of fractures and dislocations;
 - ⇒ surgery, including surgery performed by a Doctor of Podiatric Medicine (DPM) when performed in the United States;
 - ⇒ administration of anaesthetics;
 - ⇒ x-rays for diagnostic treatment purposes;
 - ⇒ obstetrical care, including prenatal or postnatal care; and
 - ⇒ laboratory services and clinical pathology when ordered by and performed under the direction of a physician;
- an optometrist's services*;
- a physiotherapist's services*;
- ambulance services*;
- services of a chiropractor, an osteopath or a podiatrist*.

* These benefits are in addition to benefits that may be available under the Extended Health Care Benefit.

b) Exclusions

Note the exclusions and limitations set out in Appendix B.

2.2.3 Hospital Expense (Outside Canada) Benefit

Coverage under this benefit is mandatory for employees of NAV CANADA residing outside Canada who are not eligible to be covered under a provincial health plan. Its purpose is to provide hospital coverage protection equivalent, as far as possible, to that available to individuals resident in Canada and covered under a provincial health or hospital plan. This benefit provides reimbursement for reasonable and customary charges for hospital confinement in a general hospital. The co-payment and deductible amounts do not apply under this benefit.

a) Eligible Expenses

Some of the more significant charges covered are:

- standard ward accommodation;
- necessary nursing services when provided by the hospital;
- laboratory, radiological and other diagnostic procedures;
- drugs prescribed and administered in hospital by an attending physician;
- use of operating and delivery rooms, anaesthetic and surgical supplies;
- services rendered by any person paid by the hospital;
- use of speech therapy facilities when prescribed by a physician;

- use of diet-counselling services when prescribed by a physician; and
- out-patient services provided by a hospital.

b) Exclusions

Note the exclusions and limitations set out in Appendix B.

2.2.4 Hospital Benefit

a) Eligible Expenses

This benefit provides reimbursement for reasonable and customary charges, up to specified amounts, for each day of hospital confinement for the cost of hospital room and board charges other than standard ward charges (i.e., semi-private or private accommodations), whether you are residing in Canada or abroad. There is a maximum amount that may be payable under this benefit for each day of confinement, depending on the benefit level you have chosen. The levels are shown in Appendix A.

You should ensure that the benefit level you have chosen is adequate for your own personal needs, taking into consideration the daily charges levied for preferred hospital accommodation in your area of residence. You may contact your pay specialist if you wish to upgrade or reduce your level of coverage.

Please note that this benefit will not necessarily cover you for the full costs of semi-private or private hospital accommodation, since that will depend on whether the level of your coverage under the Health Care Plan is sufficient to cover the actual charges you are required to pay. You will be responsible for paying any difference between the actual charges by a hospital and the maximum amount payable under your level of coverage.

b) Exclusions

Note the exclusions and limitations set out in Appendix B.

3. Premiums

The monthly premiums, effective January 1st, 2001, are as follows:

Supplementary Health Care				
Level of Coverage	Employee Share		Employer Share	
	Single	Family	Single	Family
<u>All unionised employees:</u>				
Extended Health Care Benefit + Level I Hospital Benefit:	nil	nil	\$39.16	\$69.56
Extended Health Care Benefit + Level II Hospital Benefit:	\$1.11	\$3.54	\$39.97	\$72.15
Extended Health Care Benefit + Level III Hospital Benefit:	\$5.32	\$10.35	\$43.05	\$77.15
Comprehensive Health Care				
Level of Coverage	Employee Share		Employer Share	
	Single	Family	Single	Family
<u>All unionised employees:</u>				
Extended Health Care Benefit + Level I Hospital Benefit:	nil	nil	\$115.22	\$372.18
Extended Health Care Benefit + Level II Hospital Benefit:	\$1.12	\$3.55	\$116.49	\$375.42
Extended Health Care Benefit + Level III Hospital Benefit:	\$5.33	\$10.36	\$119.57	\$380.41

You should keep in mind that periodic changes are made to the insurance plans, which may include changes to monthly premium rates. These changes will be announced on each occasion through the Pensions, Benefits, and Employee Health Programs Department.

4. Extension of Coverage During Leave

If you go on certain types of authorised leave without pay, coverage paid by NAV CANADA will be extended to you for the total period of absence. There are, however, other types of leave without pay where you may maintain your coverage for a fee. For continued coverage in these circumstances, the full premium cost must be paid in advance. Please contact your pay specialist for further details.

Your coverage will also be continued during any paid leave.

5. Termination of Coverage

Under certain circumstances, coverage may be continued for a limited period when you leave NAV CANADA. Your Pension Advisor will provide further details when you leave.

You may voluntarily cease your participation in the Supplementary portion of the Health Care Plan at any time by notifying your pay specialist, in writing. Coverage will cease no later than 2 months following the date s/he receives your notification. Any premium deductions from pay cease the first of the month prior to the date of cessation of coverage.

Example: You write to your pay specialist in January to cancel your coverage under the Health Care Plan. Your pay specialist receives your notification in February. Your coverage will cease no later than May 1st. Any premium deductions from your earnings will cease no later than April 1st.

6. Claims Procedures

6.1 Co-ordination of Benefits

6.1.1 Claims to Provincial Programs

If you reside in a province that provides a program to cover expenses that are also covered under the Health Care Plan (such as prescription drugs, artificial limbs and other assistive devices, dental services, etc.), you must first submit your claim to the provincial authorities. When that claim has been processed, you may claim under the Health Care Plan for any remaining eligible expenses.

6.1.2 Claims to Other Plans

In general, if you are covered under both the NAV CANADA Health Care Plan and another group health plan, you may claim for eligible medical expenses under both plans. However, the combined reimbursement under both plans cannot exceed the total expenses incurred. Three situations usually exist and the method of claiming is as follows:

Example 1: You are a NAV CANADA employee covered under the Health Care Plan, and you are also covered as a member of another group health plan.

In this situation, it is likely that you are covered under one plan as an active full-time employee and under the other plan as a retiree or a part-time employee. A claim for your own expenses must first be submitted to the plan that covers you as a full-time employee. If your spouse and/or children are also covered under both of your health plans, then a claim for expenses that they incur must first be submitted to the plan covering you as a full-time employee.

Example 2: You are a NAV CANADA employee covered under the Health Care Plan, your spouse is a member of another group health plan, and you (and your children) are covered as dependants under that plan.

In this situation, a claim for your own expenses must first be submitted to the NAV CANADA Health Care Plan, and your spouse must submit a claim first to his or her own plan. Once a claim has been settled by the first plan, you and your spouse may then claim any eligible expenses from the other plan for the unpaid balance. If there are expenses for your children, and if both of you cover your children under your respective plans, then a claim for the children's expenses must be first submitted to the plan of the parent having the birthday that falls first in the year.

For example, if you were born in January, and your spouse was born in June, you would first claim against your plan for the children's expenses.

If both you and your spouse are covered under the NAV CANADA Health Care Plan, there is no co-ordination of benefits for health care expenses.

Example 3: If a dental accident occurs, health plans with dental accident coverage will pay for covered expenses before dental plans.

6.2 Submission of Claims

If you have incurred expenses that are eligible for reimbursement, you should complete the authorised claim form with the appropriate information. Show your full name and address, Contract Number (25298) and Member ID, and sign the claim form. If you omit your Member ID (found on the Benefits Card) or use an incorrect number, your claim will be returned to you for correction.

When your claim is processed, a Sun Life personalised claim form will accompany your claim payment. This form will have some of your personal information pre-printed, such as your name and address. Using this form to file your next claim will simplify claims processing and help speed claims payment. If you do not have a personalised form, you may use standard Sun Life forms obtainable from your pay specialist.

If both you and your spouse are covered as members under the NAV CANADA Health Care Plan, there is no advantage for both of you to have separate coverage under the Health Care Plan. However, if you choose to do so, each of you must submit claims for your own expenses under your own Member ID found on your Benefits Card. You may not submit a claim for any unpaid balance to the Health Care Plan under your spouse's Health Care Plan Member ID.

Likewise, one member only, either yourself or your spouse must make Health Care Plan claims for children, and any balance may not then be submitted under the Member ID of the other member under the plan. You may be required to provide supporting documentation to Sun Life the first time you submit a claim for your disabled child who is age 21 or over.

Attach your original bills or receipts, making sure they provide full details for services rendered or purchases made.

6.3 Time Restriction

Claims must be submitted to Sun Life within 6 months from the end of the calendar year in which the health care expense was incurred. Claims submitted after this time period will not be paid unless Sun Life is satisfied that it was not reasonably possible to submit the claim within that time. However, except in the case of legal incapacity, no claim will be paid if it is submitted more than 18 months following the calendar year in which the health care expense was incurred.

6.4 Payment of Claims

Sun Life will forward to you an Explanation of Benefits with your benefit payment when your claim has been processed. Payment will be issued to you or, on receipt of signed instructions from you, may be issued to your spouse or to the provider of the service.

If, on admittance to a hospital, you request a semi-private or private room, you should show the Benefits Card to the hospital-admitting clerk. Most hospitals have standard claim forms that you will be asked to sign and the hospital then files a claim on your behalf. If the hospital does not use such a form, complete a claim form and attach the hospital statement of charges.

6.5 Claims Offices

Please submit claims to the Sun Life Assurance Company of Canada, Health Claims Office, at the appropriate group benefit payment office, as indicated below. Also listed are toll-free numbers for claims inquiries.

Atlantic Canada and Québec
P.O. Box 6076
Station CV
Montréal, QC H3C 4S3 1-800-361-2128

Ontario
P.O. Box 4023
Station A
Toronto, ON M5W 2P7 1-800-361-6212

Western Canada, N.W.T. and Yukon
P.O. Box 2880
Station Main
Edmonton, AB T5J 4S6 1-800-661-7334

You may call SunServe, Sun Life's interactive claims telephone service, to ask about the status of your claim. SunServe is available from 7 a.m. until midnight, Monday through Friday, from 7 a.m. until 8 p.m. Saturdays and from 5 p.m. to midnight Sundays (Eastern Standard Time). You will be connected immediately to SunServe by calling your Regional Claims Office and selecting the option for "Medical and Dental Claims Information".

SunBenefits is also a fast and convenient way to access your benefits information. If you have Internet access, you can login to SunBenefits via www.sunnet.sunlife.com, under "For Plan Members". Just use the access ID and PIN provided to you by Sun Life.

For travel-related emergencies, services are provided by World Access. In the U.S. and Canada, call 1-800-854-7589. In all other countries, call (519) 742-6768 collect.

6.6 Claims Appeal Process

Where you do not agree with a decision made by Sun Life and wish a review of your claim, you should contact the Pensions, Benefits, and Employee Health Programs Department.

Appendix A: Table of Health Care Maximum Eligible Expenses

Type of Benefit	What is the maximum eligible expense per person?	How much is reimbursed?	Does the deductible apply?	What is the maximum amount that can be reimbursed?
Basic Health Care Benefit	3 times the amount otherwise payable under the Health Insurance Act 1972 of Ontario	100%	No	-
Chiropodist/podiatrist, massage therapist, naturopath or osteopath	\$300/calendar year/type of practitioner	80%	Yes	\$240
Chiropractor	\$500/calendar year	80%	Yes	\$400
Electrolysis treatments when performed by an electrologist** or a physician	\$20/visit	80%	Yes	\$16
Emergency Travel Benefit	specified expenses incurred on an emergency basis while travelling outside the province of residence (Out-of-Province Benefit: \$100,000/period of travel)	100%	No	-
Eyeglasses and contact lenses	\$200/2-calendar year period***	80%	Yes	\$160
Hearing aids	\$500 every 60-month period	80%	Yes	\$400
Hospital Benefit	Level I: \$60/day Level II: \$100/day Level III: \$150/day	100%	No	\$60 \$100 \$150
Insulin Jet-Injector Device	\$760 every 36-month period	80%	Yes	\$608
Nursing services	\$15,000/calendar year	80%	Yes	\$12,000
Orthopaedic brassieres	\$100/calendar year	80%	Yes	\$80
Orthopaedic shoes	\$150/calendar year	80%	Yes	\$120
Psychologist*	\$1,000/calendar year	80%	Yes	\$800
Referral Benefit: specified expenses incurred out-of-province on a referral basis	\$25,000/illness	80%	Yes	\$20,000
Smoking-cessation aids	\$1,000/lifetime	80%	Yes	\$800
Speech language pathologist*	\$500/calendar year	80%	Yes	\$400
Viagra	\$1,200/calendar year	80%	Yes	\$960
Wheelchairs replacement cost	covered every 60 months	80%	Yes	-
Wigs	\$500/lifetime for members suffering from total hair loss as a result of illness	80%	Yes	\$400

Example: You are submitting a claim for the first time under the Health Care Plan. The claim is for the amount of \$250 for prescription eyeglasses. Since the maximum eligible expense for eyeglasses and contact lenses is \$200 in any 2-calendar year period, only \$200 of the \$250 claim will be considered for reimbursement. Assuming that you are a single employee, \$25 of this \$200 eligible expense will be used to satisfy your annual deductible, leaving a balance of \$175 eligible for reimbursement. With a reimbursement level of 80%, this plan will pay you a benefit of \$140 (80% x \$175).

* Requires prescription of a physician.

** Requires prescription of a psychiatrist or a psychologist.

*** See Section 2.2.1 (c) for an explanation of the administration of the 2-year period.

Appendix B: Health Care Exclusions and Limitations

1. Exclusions

No benefit is payable for *charges* in respect of:

- services for which benefits are payable under any Workers' Compensation Act, any similar statute or by any government agency;
- services or supplies, rendered or prescribed, by a person who is ordinarily resident in the patient's home or who is related to the patient by blood or marriage;
- operations, treatments or supplies considered by Sun Life to be for cosmetic purposes, or for conditions not detrimental to health, except those required as a result of accidental injury (or expressly provided for under the Health Care Plan);
- any services of a practitioner that, in the opinion of Sun Life are not within the practitioner's area of expertise and do not require the skills and qualifications of such a practitioner;
- services or supplies normally rendered without charge;
- services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes;
- services provided by a physician licensed and practising in Canada where the participant is eligible to be covered under a provincial health plan, unless such services are specifically included in the Extended Health Care Benefit; and

No benefit is payable for *expenses* in respect of:

- experimental products or treatments for which substantial evidence provided through objective clinical testing of the product's or treatment's safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the satisfaction of Sun Life;
- drugs that, in Sun Life's opinion, are experimental;
- publicly advertised items or products that, in Sun Life's opinion, are household remedies;
- contraceptives, other than oral;
- vitamins (except injectables), minerals and protein supplements other than those under Section 2.2.1 b);
- therapeutic nutrients other than those under Section 2.2.1 b);
- diets and dietary supplements, infant foods and sugar or salt substitutes;
- lozenges, mouthwashes, non-medicated shampoos, contact lens care products and skin cleanser, protectives, or emollients;
- surgical supplies and diagnostic aids;
- drugs that are used for cosmetic purposes;
- drugs that are used for a condition or conditions not recommended by the manufacturer of the drugs;
- items purchased primarily for athletic use;
- repairs or replacement of purchased durable equipment;
- the regular treatment of an injury or disease that existed prior to your dependant's departure, or your departure, from your province of residence, or
- benefits which are legally prohibited by the government from coverage.

The payment of a single purchase of items eligible under the *Drug Benefit* is limited to the cost of a supply, which could reasonably be consumed or used within a 3-month period following such payment.

2. Limitations

No benefit is payable:

- for the portion of any charges that is payable under a provincial health or hospital plan or of a provincially sponsored program;
- for the portion of charges that is the legal liability of any other party;
- under the Basic Health Care Benefit or the Extended Health Care Benefit (except for the Travel Benefit), for the portion of charges for services rendered or products provided in a hospital outside Canada that

would normally be payable under a provincial health or hospital plan if the services had been rendered or products provided in a hospital in Canada. (Such charges are covered under the Extended Health Care Out-of-Province Benefit.); and

- for co-payment charges or similar charges for hospital care that are in excess of charges payable by a provincial or territorial government health or hospital plan and that are not charges made for utilisation of semi-private or private accommodation.

Appendix C: Glossary

Term	Definition
<i>Chiroprapist/Podiatrist</i>	A person licensed by the appropriate provincial licensing authority, or in those provinces where there are no licensing authority members of the Canadian Association of Foot Professionals or, in the absence of such an association, a person with comparable qualifications as determined by Sun Life.
<i>Chronic Disease</i>	A condition that exists beyond the usual course of an acute disease or beyond a reasonable time for tissue damage to heal. Any such condition that lasts longer than 6 months may be considered chronic.
<i>Chiropractor</i>	A member of the Canadian Chiropractic Association, or of a provincial association affiliated with it or, in the absence of such an association, a person with comparable qualifications as determined by Sun Life.
<i>Dentist</i>	A person licensed to practice dentistry by the provincial licensing authority or, in the absence of such an authority, a person with comparable qualifications as determined by Sun Life.
<i>Electrologist</i>	A person who, as determined by Sun Life, qualifies as a certified electrologist.
<i>Fee Guide</i>	Charges established by provincial dental associations for specified services provided by dentists in their provinces.
<i>Hospital</i>	A legally licensed hospital that provides facilities for diagnosis, major surgery and the care and treatment of persons suffering from disease or injury on an in-patient basis, with 24-hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialised treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.
<i>Naturopath</i>	A member of the Canadian Naturopathic Association or any provincial association affiliated with it or, in the absence of such an association, a person with comparable qualifications as determined by Sun Life.
<i>Nurse</i>	A registered nurse, registered nursing assistant, licensed practical nurse, or certified nursing assistant who is listed on the appropriate provincial registry or, in the absence of such a registry, a nurse with comparable qualifications as determined by Sun Life.
<i>Ophthalmologist</i>	A person licensed to practice ophthalmology.
<i>Optometrist</i>	A member of the Canadian Association of Optometrists or of a provincial association affiliated with it or, in the absence of such an association, a person with comparable qualifications as determined by Sun Life.
<i>Osteopath</i>	A person who holds the Degree of Doctor of Osteopathic Medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association or, in the absence of such an association, a

Term	Definition
	person with comparable qualifications as determined by Sun Life.
<i>Physician</i>	A doctor of medicine (M.D.) legally licensed to practice medicine.
<i>Physiotherapist</i>	A member of the Canadian Physiotherapy Association or of a provincial association affiliated with it or, in the absence of such an association, a person with comparable qualifications as determined by Sun Life.
<i>Psychologist</i>	A permanently certified psychologist who is listed on the appropriate provincial registry in the province where the service is rendered or, in the absence of such a registry, a person with comparable qualifications as determined by Sun Life.
<i>Registered Massage Therapist</i>	A person licensed by the appropriate provincial licensing body or, in the absence of a provincial licensing body, a person whose qualifications Sun Life determines to be comparable with those required by a licensing body.
<i>Registered Pharmacist</i>	A person who is licensed to practice pharmacy and who is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.
<i>Speech Language Pathologist</i>	A person who holds a Master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with or, in the absence of such an association, a person with comparable qualifications as determined by Sun Life.

Section IV- Dental Care Plan

The Dental Care Plan provides coverage for specific services and supplies that are not covered under a provincial plan. Further, this covers only reasonable and customary dental treatment, necessary to prevent or correct dental disease or defect, provided the treatment is consistent with generally accepted dental practices.

1. Eligibility and Effective Date of Coverage

1.1 Employee Eligibility

Generally speaking, employees appointed on a full-time or a part-time basis (i.e., assigned to work more than 1/3 of the normally scheduled full-time hours of work for their occupational group) are eligible, on a compulsory basis, as follows:

Appointment Status	Eligibility Date	Coverage Date	Example
indeterminate period	from the date of appointment	three months after the eligibility date	Appointed: 12/06/00 Eligible: 12/06/00 Coverage: 12/09/00
term of more than 6 months	from the date of appointment	three months after the eligibility date	Appointed: 12/06/00 Eligible: 12/06/00 Coverage: 12/09/00
term of 6 months or less, and appointed to another term of less than 6 months	from the day following completion of 6 months continuous employment	three months after the eligibility date	Term A: 12/06/00 to 08/09/00 Term B: 09/09/00 to 28/02/01 Eligibility: 12/12/00 Coverage: 12/03/01
term of 6 months or less, and appointed for a term of another 6 months or more	from the date of the new appointment	three months after the eligibility date	Term A: 12/06/00 to 08/09/00 Term B: 09/09/00 to 30/04/01 Eligibility: 09/09/00 Coverage: 09/12/00

Dental Care Plan coverage begins after a waiting period of exactly 3 months of continuous employment.

Your insurance cannot become effective while you are not actively at work. If, for example, you are off sick on the day your insurance would otherwise become effective, your insurance will be postponed until you return to regular active duties.

1.2 Dependants' Eligibility

Your dependants become eligible for coverage when you become eligible or, if acquired later, upon becoming your dependant.

Your eligible dependants include:

- your legal spouse of either gender or the person who has lived with you as your spouse in a permanent, exclusive relationship for a continuous period of at least one year and continues to live with you as such; and
- unmarried children of you or your spouse, including adopted children, stepchildren, foster children, or children for whom you or your spouse is the legal guardian, and who are:
 - ⇒ under 21 years of age;
 - ⇒ age 21 or older and depend on you for support because of a mental or physical disability, provided they become disabled before age 21. (This description should apply to your child on the date you become eligible for coverage under the Dental Care Plan, otherwise the child has to have been covered under the Dental Care Plan immediately before his or her 21st birthday. If the child becomes disabled after reaching the age of 21, s/he must have been covered as a student at the time the disability began.); and
 - ⇒ if older, while full-time students enrolled in a school or a university up to age 25 (26 in Québec).

1.3 Benefits Card

Once you become covered, you will receive a Benefits Card. This card will contain your name, and the Member ID that has been assigned to you to identify you to Sun Life when you file your claims. You must record your Member ID on all claims that you submit for yourself and your eligible dependants and all correspondence with Sun Life.

Should you lose your Benefits Card, please contact your pay specialist to obtain a replacement card.

2. Coverage

2.1 Co-insurance

The plan will reimburse you for a percentage of the cost of the covered expenses you have incurred. This percentage is applied to the amount of expenses that is in excess of the annual deductible amount. For example, the plan will reimburse you:

<i>at 90% for</i>	Diagnostic, Preventive, Minor Restorative, Endodontics, Periodontics, Minor Prosthodontic, Surgery, and Adjunctive Services.
<i>at 50% for</i>	Major Restorative, Major Prosthodontic and Orthodontics services.

You must pay the remainder.

A detailed description of eligible services is provided in Appendix A.

Note: There are specific limits on how often certain services will be reimbursed. Please check Appendix B to see where these limits apply.

2.2 Fee Guides

2.2.1 Canadian Residents

When you incur expenses for a particular eligible service or item, the Dental Care Plan recognises only those amounts up to the tariff shown for the applicable service or item in the current (as approved by the NAV CANADA Joint Council) dental fee guide in effect in the province or territory in which the service is rendered. You will have to bear any portion of any expense in excess of that general level.

If you incur charges outside Canada on your behalf or on behalf of a covered dependant, the amounts recognised will be those that would have applied if the charges had been incurred in your province of residence. This means that no reimbursement will be made under the Dental Care Plan for those services that would have been covered by a provincial dental plan if the services had been rendered in your province of residence.

2.2.2 Residents Outside Canada

When you incur expenses for a particular service or item, the plan will reimburse the actual incurred expenses provided those amounts are considered "reasonable and customary" in that region as determined by Sun Life. Any portion of an expense in excess of that "reasonable and customary" amount will not be covered under the Dental Care Plan. The amount that would have been incurred in Ontario for the dental procedures involved will be used in determining the annual and lifetime limits on the reimbursement of expenses, so that employees who receive treatment abroad will be in the same relative position as if they had received treatment in Ontario.

2.3 Limitations on Reimbursement

2.3.1 Maximum Reimbursement for Dental Services

Except for orthodontic work, there is a reimbursement limit of \$1,250 per calendar year per covered person for dental expenses. If you, your eligible spouse and/or children begin coverage under the Dental Care Plan on or after July 1st of any given year, the maximum reimbursement amount per person, excluding orthodontic services, is \$625 for that year.

Orthodontic services are subject to a separate lifetime limit of \$2,500 per covered person.

2.3.2 Deductible Amount

For each calendar year, there is a minimum deductible amount on all dental expenses. Only the eligible expenses you incur during the year that exceed that deductible amount are eligible for reimbursement.

The annual deductible amount is \$25 per covered person. However, where eligible expenses are incurred by more than one person in a family in a calendar year, the deductible amount will be limited to \$50.

Carry-over deductible: If the first dental expense in a calendar year is incurred in the last quarter of the year (October-December) and the applicable deductibles have been satisfied, a new deductible will not be applied in the following year.

2.3.3 Pre-determination of Benefits

When the estimated cost of treatment suggested by your dentist will exceed \$300, you are strongly urged to submit a treatment plan to Sun Life before proceeding with these services. Upon receipt of a treatment plan, Sun Life will tell you the benefits payable under the Dental Care Plan for the services that are proposed. Consequently, it is in your own best interest to determine what will be paid before the work is begun.

3. Premiums

The employer pays the premium for all active employees.

Effective January 1st, 2001, the monthly employer paid premium is \$58.34.

You should keep in mind that periodic changes are made to the insurance plans, which may include changes to monthly premium rates. These changes will be announced on each occasion through the Pensions, Benefits, and Employee Health Programs Department.

4. Extension of Coverage During Leave

If you go on certain types of authorised leave without pay, coverage paid by NAV CANADA will be extended to you for the total period of absence. There are, however, other types of leave without pay where you may maintain your coverage for a fee. For continued coverage in these circumstances, the full premium cost must be paid in advance. Please contact your pay specialist for further details.

Your coverage will also be continued during any paid leave.

5. Termination of Coverage

5.1 General

Under certain circumstances, coverage may be continued for a limited period when you leave NAV CANADA. Your Pension Advisor will provide further details when you leave.

5.2 Exceptions

If a certain dental treatment (for example, root canal treatment where the pulp chamber is opened before the date of termination) began while you and/or your dependants were covered under the Dental Care Plan, coverage for that treatment will continue only if it is completed within 31 calendar days of the termination date.

With regard to orthodontic services, treatment that began for a child before the date of termination of coverage or the date the child attained the age 21 (or 25 (26 in Québec) in the case of a student) will be covered for the quarter that includes the month of termination or the month of the child's 21st or 25th (26th in Québec) birthday.

6. Claims Procedures

6.1 Co-ordination of Benefits

In general, if you are covered under both the NAV CANADA Dental Care Plan and another group dental care plan, you may claim for eligible dental expenses under both plans. However, the combined reimbursement under both plans cannot exceed the total expenses incurred. Three situations usually exist and the method of claiming, as follows:

Example 1: You are a NAV CANADA employee covered under the Dental Care Plan, and you are also covered as a member of another group dental care plan.

In this situation, it is likely that you are covered under one plan as an active full-time employee and under the other plan as a retiree or a part-time employee. A claim for your own expenses must first be submitted to the plan that covers you as a full-time employee. If your spouse and/or children are also covered under both of your dental care plans, then a claim for expenses that they incur must first be submitted to the plan covering you as a full-time employee.

Example 2: You are a NAV CANADA employee covered under the Dental Care Plan, your spouse is a member of another group dental care plan, and you (and your children) are covered as dependants under that plan.

In this situation, a claim for your own expenses must first be submitted to the NAV CANADA Dental Care Plan, and your spouse must submit a claim first to his or her own plan. Once a claim has been settled by the first plan, you and your spouse may then claim any eligible expenses from the other plan for the unpaid balance. If there are expenses for your children, and if both of you cover your children under your respective plans, then a claim for the children's expenses must be first submitted to the plan of the parent having the birthday that falls first in the year.

For example, if you were born in January, and your spouse was born in June, you would first claim against your plan for the children's expenses.

This example also applies if both you and your spouse are covered under the NAV CANADA Dental Care Plan, but for **dental care claims only**.

Example 3: If a dental accident occurs, health plans with dental accident coverage will pay for covered expenses before dental plans.

6.2 Submission of Claims

If you have incurred expenses that are eligible for reimbursement, you should complete the authorised claim form with the appropriate information. Show your full name and address, Contract Number (25298) and Member ID, and sign the claim form. If you omit your Member ID (found on the Benefits Card) or use an incorrect number, your claim will be returned to you for correction. The dentist must complete his or her section of the claim form.

Note: If your dental office provides electronic claims submission, you do not need to complete and submit a claim form. You should ensure, however, that your dentist's office has your correct and complete address on file.

When your claim is processed, a Sun Life personalised claim form will accompany your claim payment. This form will have some of your personal information pre-printed, such as your name and address. Using this form to file your next claim will simplify claims processing and help speed claims payment. If you do not have a personalised form, you may use standard Sun Life forms obtainable from your pay specialist.

If both you and your spouse are covered as members under the NAV CANADA Dental Care Plan, the same procedures as described under Example 2 above will apply.

Attach your original bills or receipts, making sure they provide full details for services rendered or purchases made.

6.3 Time Restriction

Claims must be submitted to Sun Life within 15 months of the date on which the dental care expense is incurred. Claims submitted after this time period will not be paid unless Sun Life is satisfied that it was not reasonably possible to submit the claim within that time. However, except in the case of legal incapacity, no claim will be paid if it is submitted more than 24 months after the dental care expense was incurred.

For orthodontic treatment, a claim must be submitted within 15 months of the date of each monthly visit throughout the treatment period. This allows Sun Life to reimburse, in turn, covered expenses on a monthly basis.

Recall visits (i.e., return appointments to the dentist's office for oral examination, dental cleaning and polishing, topical application of fluoride, and bitewings) must be scheduled every 9 months. They will not be covered if scheduled on a more frequent basis.

6.4 Payment of Claims

Sun Life will forward to you an Explanation of Benefits with your benefit payment when your claim has been processed. Payment will be issued to you or, on receipt of a signed instructions form from you (Authorised to Redirect Payment form), may be issued to your spouse or to the provider of service.

6.5 Claims Offices

Please submit claims to Sun Life Assurance Company of Canada, Dental Claims Office, at the appropriate group benefit payment office, as indicated below. Also listed are toll-free numbers for claims inquiries.

Atlantic Canada and Québec
P.O. Box 6076
Station CV
Montréal, QC H3C 4S3 1-800-361-2128

Ontario
P.O. Box 4023
Station A
Toronto, ON M5W 2P7 1-800-361-6212

Western Canada, N.W.T. and Yukon
P.O. Box 2880
Station Main
Edmonton, AB T5J 4S6 1-800-661-7334

You may call SunServe, Sun Life's interactive claims telephone service, to ask about the status of your claim. SunServe is available from 7 a.m. until midnight, Monday through Friday, from 7 a.m. until 8 p.m. Saturdays and from 5 p.m. to midnight Sundays (Eastern Standard Time). You will be connected immediately to SunServe by calling your Regional Claims Office and selecting the option for "Medical and Dental Claims Information".

SunBenefits is also a fast and convenient way to access your benefits information. If you have Internet access, you can login to SunBenefits via www.sunnet.sunlife.com, under "For Plan Members". Just use the access ID and PIN provided to you by Sun Life.

6.6 Claims Appeal Process

Where you do not agree with a decision made by Sun Life and wish a review of your claim, you should contact the Pensions, Benefits, and Employee Health Programs Department.

Appendix A: Eligible Dental Care Services

Eligible dental services mean services listed here, when rendered by a dentist or dental specialist, or rendered by a dental hygienist under the direct supervision of a dentist or dental specialist, or rendered by a dental mechanic (also referred to as a denturist or denturologist) who is licensed to provide services in the province or territory in which the service was received, and who is permitted by law to deal directly with the public. This section should be read in conjunction with Appendix B that lists exclusion and limitations on dental services and supplies. Where it cannot be ascertained that the dental services rendered are covered services, Sun Life will identify which of the covered services listed below could be considered to be alternative services, and will base reimbursement on those services.

Category	Covered Services	
Diagnostic	<i>Examination and Diagnosis (90%)</i>	<ul style="list-style-type: none"> complete oral examination recall oral examination (once every 9 months) specific oral examination emergency oral examination treatment planning
	<i>Radiographs (90%)</i>	<ul style="list-style-type: none"> periapical (one complete series every 3 years) occlusal bitewings (once every 9 months) extra-oral sialography, uses of dyes panoramic (once every 3 years) interpretation of radiographs from another source tomography
	<i>Test, Laboratory Examinations (90%)</i>	<ul style="list-style-type: none"> biopsy of oral tissue pulp-vitality tests
Preventive	<i>Routine Services (90%)</i>	<ul style="list-style-type: none"> dental cleaning and polishing (once every 9 months) topical application of fluoride (once every 9 months) pit and fissure sealants (for children under 15 years of age only) caries control enameloplasty space maintainers (not involving movement of teeth) oral hygiene instructions
Restorative	<i>Minor (90%)</i>	<ul style="list-style-type: none"> amalgam silicate acrylic or composite pin reinforcements for these restorations
	<i>Major (50%)</i>	<ul style="list-style-type: none"> gold foil gold inlays retentive pins, posts and cores porcelain inlays crowns other restorative services
Endodontics	(90%)	<ul style="list-style-type: none"> pulp capping pulpotomy root canal therapy periapical services other endodontic procedures
Periodontics	(90%)	<ul style="list-style-type: none"> non-surgical services

Category	Covered Services	
		<ul style="list-style-type: none"> • surgical services • post-surgical treatment • occlusal equilibration (not exceeding 8 time units per year) • scaling and root planing • other periodontic services
Prosthodontics	<i>Minor Services for Removable Dentures (90%)</i>	<ul style="list-style-type: none"> • repairs • adjustments • relining and rebasing (once every 3 years)
	<i>Major (50%)</i>	<ul style="list-style-type: none"> • exams, films and diagnostic casts • addition of tooth to a removable denture • complete dentures • partial dentures • pontics (fixed bridges) • retainers • abutments (fixed bridges) • retentive pins in abutments • repairs of fixed appliances • other prosthodontic services
Oral Surgery	(90%)	<ul style="list-style-type: none"> • uncomplicated removal • surgical removal and tooth repositioning • alveoplasty, gingivoplasty, stomatoplasty, osteoplasty, tubero-plasty • removal of excess mucosa • surgical excision • removal of cyst • surgical incision • removal of impacted teeth • repair of soft tissue • frenectomy, dislocations • miscellaneous surgical services
Orthodontic Services	<i>Observations and Adjustment (50%)</i>	<ul style="list-style-type: none"> • orthodontic exam • films • orthodontic diagnostic casts • surgical services • observation and adjustments • repairs, alterations
	<i>Appliances (50%)</i>	<ul style="list-style-type: none"> • removable appliances • fixed appliances • retention appliances • appliances to control harmful habits
Adjunctive Services	(90%)	<ul style="list-style-type: none"> • emergency services not otherwise specified • anaesthesia in connection with oral surgery and drug injections • consultation • house call, hospital call and special office visit

Appendix B: Dental Care Exclusions and Limitations

1. General

No benefit is payable for the following dental services and supplies:

- or any portion thereof, that are covered under any provincial, territorial or other public dental, hospital or health plan under which the person is eligible;
- or any portion thereof, that are the legal liability of any other party;
- rendered or provided to a person who is entitled without charge pursuant to any law, including, but not limited to, the Workers' Compensation Act or a similar law, or for which there is no cost to the person except for the existence of insurance against such cost;
- received in a hospital owned or operated by a government, unless the person is required to pay for such services or supplies regardless of the existence of insurance;
- rendered outside Canada to persons residing in Canada, or to children of a member residing in Canada, that would be payable under a provincial health, dental or hospital plan if the services had been rendered in Canada;
- involving the use of precious and non-precious metals, if such treatment could have been rendered at lower cost by means of a reasonable substitute consistent with generally accepted dental practice, except for that portion of expenses that would have been incurred for treatment by means of a reasonable substitute;
- for which user fees, co-insurance charges or similar charges are made that are in excess of charges payable by a government dental, hospital or health plan;
- that are not yet approved by the Canadian Dental Association or that in the opinion of Sun Life, are clearly experimental in nature;
- that, in the opinion of Sun Life, are rendered principally for cosmetic purposes including, but not limited to, porcelain or composite facings on crowns or pontics on molar teeth;
- related to the purchase, repair, modification or replacement of a duplicate prosthodontic appliance, for any reasons;
- purchased before the date the person became covered under the Dental Care Plan;
- for an appliance or a modification of one where an impression is made for such appliance or a modification before the person became covered under the Dental Care Plan; for crowns, bridges and gold restorations for which a tooth was prepared before the person became covered under the Dental Care Plan; for root canal therapy where the pulp chamber was opened before the person became covered under the Dental Care Plan;
- rendered as a result of a congenital or developmental malformation that is not a Class I, II or III malocclusion;
- for a periodontal appliance, occlusal equilibration, and other related service as a result of a temporomandibular joint dysfunction (TMJ dysfunction) or vertical dimension correction;
- related to implants; and
- for an orthodontic treatment, in respect of a member or his or her eligible spouse, where the initial appliance was installed before the person became covered for such service under the Dental Care Plan.

2. Specific Limitations with Respect to Major Prosthodontic Services

Services for the installation of prosthodontic appliances (for example, fixed bridges, pontics and abutments; temporary or permanent, partial or complete dentures) constitute eligible dental services only if they are rendered for:

- an initial prosthodontic appliance;
- the replacement of an existing prosthodontic appliance, including the addition of teeth to an existing appliance, if:
 - ⇒ the replacement or the addition of teeth is required because at least one additional natural tooth was extracted after the insertion of the existing appliance, and the appliance could not have been made serviceable. If the existing appliance could have been made serviceable, only the expense for that portion of the replacement appliance that replaces the teeth extracted will be covered;
 - ⇒ the existing appliance is at least 5 years old and cannot be made serviceable;

- ⇒ the existing appliance was temporarily installed, provided that the replacement appliance is installed within 12 months of insertion of the temporary appliance and that such replacement appliance will be deemed permanent for the purposes of this provision;
- ⇒ the replacement appliance is required as a result of the installation of an initial opposing denture after the date the person becomes covered under the Dental Care Plan;
- ⇒ the replacement appliance is required as a result of accidental dental injury to a natural tooth that occurred after the date the person became covered under the Dental Care Plan; or
- the replacement of a crown when the existing restoration is at least 5 years old and cannot be made serviceable.

Section V: Business Travel Accidental Death and Dismemberment Insurance

1. Eligibility and Effective Date of Coverage

1.1 Employee Eligibility

Generally speaking, employees appointed on a full-time or part-time basis (i.e., assigned to work more than 1/3 of the normally scheduled hours of work for his/her occupational group), who are under age 75 and residing in Canada, are covered automatically when they travel for business purposes.

1.2 Dependants' Eligibility

Under the Business Travel Accidental Death and Dismemberment Plan:

- a spouse is defined as a person, under age 75 and who is either legally married to the employee or a person who cohabits with the employee and has been publicly represented as his/her domestic partner for a period of one year or longer in the community in which they both reside and continue to be represented; and
- a dependant child means any unmarried, natural child, step child or legally adopted child of the employee or a child of the employee's spouse who is in the care, custody and control of the employee and living with the employee in a parent-child relationship, and who, in either case is:
 - ⇒ under age 21 and is a dependant;
 - ⇒ under age 25 and is a dependant in full-time attendance as a student at an accredited institute of higher learning or on a vacation therefrom; or
 - ⇒ a dependant by reason of mental or physical infirmity.

2. Coverage

2.1 General

Business Travel AD&D is payable, in addition to any other insurance benefits, for paralysis, loss of life, limb, sight, speech or hearing which is the result of accidental bodily injuries and which occur within 365 days from the date of the accident.

The coverage applies during your travel and sojourn while on NAV CANADA business, provided you are travelling to a point or points located away from NAV CANADA premises and the period of assignment is not more than 60 days. Coverage begins at the actual start of an anticipated trip whether it be from your place of employment, home or other location. This coverage terminates upon return to your home or your place of employment. Commutation travel is not covered under the Business Travel Accidental Death and Dismemberment Plan.

You will also be covered as follows:

- while as a passenger, pilot or member of the crew, riding in, boarding or alighting from the aircraft described below, provided such aircraft is operated by a properly certified pilot, including non-scheduled flights for the purposes of equipment checks and calibration;
- in consequence of making a parachute jump from such aircraft for the purpose of self-preservation; or
- in consequence of being struck by such aircraft.

Your spouse and dependent children will be covered for any accident, which occurs during travel for relocation and the purpose of house-hunting.

Under certain circumstances, a guest (i.e., any person receiving an expressed or implied invitation from NAV CANADA or from any other person having authority to extend such invitation and whose expenses and travel arrangements are paid for by NAV CANADA) can also be covered.

2.2 Benefit Amounts

Benefit amounts are equal to:

CLASS	COVERAGE
I - Union Employees	up to 3X annual earnings (to a maximum of \$350,000)
II - Management Group Employees	up to 4X annual earnings (to a maximum of \$500,000)
III - Spouses and Dependant Children of Class I and II Employees (during travel for relocation and house-hunting only)	up to \$100,000 for your spouse up to \$10,000 for each child
IV - Guests of NAV CANADA	up to \$50,000

Coverage terminates upon the earlier of termination/retirement or attainment of age 75.

In the event of your death, the Benefit Amount is payable to the beneficiary (ies) you have named under the Basic Life Insurance Plan or, in the absence of such designation, to your Estate.

2.3 Schedule of Losses

If loss of life, limb, speech, hearing, sight, indemnity, loss of use and paralysis results in any one of the following specific losses within one year from the date of accident, CIGNA Life will pay the benefit specified below, based on the Principal Sum which is equal to the benefit amount in 2.2 above, provided however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident, directly and independently of all other causes from bodily injuries.

Injury	Benefit Amount
Quadriplegia	two times the Principal Sum
Paraplegia	two times the Principal Sum
Hemiplegia	two times the Principal Sum
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 entire sight of one eye	the Principal Sum
Loss of one foot and entire sight of one eye	the Principal Sum
Loss of speech and hearing	the Principal Sum
Loss of use of both arms or both hands	the Principal Sum
Loss of one arm or one leg	three-quarters of the Principal Sum
Loss of use of one arm or one leg	three-quarters of the Principal Sum
Loss of one hand or one foot	two-thirds of the Principal Sum
Loss of entire sight of one eye	two-thirds of the Principal Sum
Loss of use of one hand	two-thirds of the Principal Sum
Loss of speech or hearing	two-thirds of the Principal Sum
Loss of thumb and index finger of the same hand	one-third of the Principal Sum
Loss of four fingers of the same hand	one-third of the Principal Sum
Loss of hearing in one ear	one-quarter of the Principal Sum
Loss of all toes of the same foot	one-eighth of the Principal Sum

“Loss” means:

- with respect to hand or foot, actual severance through or above the wrist or ankle joint;
- with respect to arm or leg, actual severance through or above the elbow or knee joint;
- with respect to eye, the total and irrecoverable loss of sight;
- with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree;

- with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device;
- with respect to thumb and index finger, actual severance through or above the first phalange;
- with respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand; or
- with regard to toes, the actual severance of both phalanges of all toes of the same foot.

“Loss” as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs) and hemiplegia (paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

“Loss of Use” shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to CIGNA Life to be permanent.

2.4 Emergency Medical Reimbursement Expense (Applicable to Employees Only)

If on account of such injuries or sickness, you (the employee) require Emergency Medical treatment by a legally qualified physician or surgeon, confinement in a legally constituted hospital, employment of a trained nurse, x-ray examination or the use of an ambulance, CIGNA Life, subject to the lifetime maximum amount of \$500,000 per person, will pay the actual cost of the following covered expenses incurred while outside of Canada for trips of 60 days or less to the extent that such expenses are of an emergency nature and do not duplicate the cost of any such services covered under the terms of any health insurance services plan.

“Emergency Medical” means any unforeseen illness or accidental bodily injury occurring while this insurance is in force, which requires immediate emergency medical treatment by a physician.

2.4.1 Eligible Expenses

Covered emergency expenses include the following:

- drugs and medicines that require a doctor’s prescription and are listed in the current Compendium of Pharmaceuticals and Specialties;
- private duty nursing, prescribed by a physician as being medically necessary, where the service is provided by a registered nurse who is not a member of your family or ordinarily a resident in your home, up to a maximum of \$1,000 per person;
- transportation by a local licensed ambulance service for emergency medical reasons;
- diagnostic laboratory and X-ray examination;
- administration of anaesthesia, oxygen, blood and blood transfusions;
- charges made by a hospital for reasonable and customary expenses for semi-private room and board and other necessary services and supplies, including drugs administered while confined to hospital for emergency medical care and treatment for up to a maximum of 30 days; and
- charges made by a physician for professional services for emergency medical treatment or surgical procedures.

2.4.2 Exclusions

No benefit is payable for:

- expenses paid for or furnished under the terms of any other health plan arranged through the employer;
- services provided by an agency or department of any government which are normally provided free of charge;
- non-emergency medical treatment, routine health check-ups, eye and ear examinations, eye glasses and hearing aids; or treatment which can be reasonably delayed until return to Canada;
- dental care;
- hospital charges for non-medical services, such as radio or telephone;
- services not listed as covered expenses;
- services rendered before coverage became effective or after termination of employment or termination of insurance;

- cosmetic surgery or treatment, except as required for correction of damage caused by accidental injury sustained while this coverage is in force;
- dental services or supplies and appliances, except as previously mentioned;
- services or supplies that are available through any plan established pursuant to the laws or regulations of any government, including any motor vehicle no fault coverage required by statute;
- any service to the extent that any government prohibits payment of benefits;
- services, drugs or supplies which are deemed experimental in nature;
- delivery and transportation charges;
- services and supplies which are required for recreation or sport but which are not medically necessary for regular activities;
- services received for confinement which is primarily for chronic or custodial care;
- services received in a government hospital unless you are required to pay for such services;
- services to which you are entitled without charge, or for which there would be no charge if there were no insurance;
- services received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group;
- expenses in respect of services provided by a member of your family or by a person customarily living with you ;
- chronic alcoholism or drug addiction;
- mental or nervous disorders or psychiatric treatment, unless necessitating hospital or institutional confinement, in which case coverage shall not extend beyond 3 months;
- AIDS or AIDS-related disease or disorders; or
- any condition for which you received medical advice for treatment during the 90 days immediately prior to becoming insured, until after the expiration of 12 months from the date you are eligible for insurance.

2.5 Emergency Evacuation Benefit

If an injury or sickness commencing during the course of a trip results in your necessary emergency evacuation, CIGNA Life will pay benefits for covered expenses incurred by up to 10% of the Emergency Medical Reimbursement Expense Benefit maximum. A legally licensed physician who certifies that must order an emergency evacuation the severity of your injury or sickness warrants your emergency evacuation.

Emergency evacuation means that:

- a) your medical condition warrants immediate transportation from the place where you are injured or sick to the nearest hospital where appropriate medical treatment can be obtained; or
- b) after being treated at a local hospital, your medical condition warrants transportation to the place where you reside (provided such residence is located in the United States or Canada) to obtain further medical treatment or to recover; or
- c) both a) and b) above.

Covered expenses are expenses, up to the maximum, for transportation, medical services and medical supplies necessarily incurred in connection with your emergency evacuation.

All transportation arrangements made for evacuating you must be by the most direct and economical route. Expenses for special transportation must be:

- recommended by the attending physician; or
- required by the standard regulations of the conveyance in which you are transported.

The attending physician must recommend expenses for medical services and supplies.

Transportation means any land, water or air conveyance required to transport you during an emergency evacuation.

Special Transportation includes, but is not limited to, air ambulance, land ambulances, and private motor vehicles.

Sickness means sickness or disease, which causes loss covered herein for which symptoms are manifested while the policy is in force.

2.6 Repatriation Benefit

When injuries covered by this policy result in a loss of life of an insured person outside 150 km from your city of permanent residence or outside Canada and occurs within 365 days from the date of the accident, CIGNA Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, to a maximum of \$10,000.

2.7 Family Transportation Benefit

When injuries covered by this policy, result in an insured person being confined as an Inpatient in a hospital outside 150 km from the city of permanent residence or outside Canada and requires personal attendance of a member of the insured person's immediate family as recommended by the attending physician, in writing, CIGNA Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to confined insured person, to a maximum of \$10,000.

"Member of the immediate family" means insured person's spouse, legal or common-law, parents, grandparents, children over age 18, brother or sister.

2.8 Home Alteration and Vehicle Modification

In the event an insured person sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, CIGNA Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of accident for:

- the one-time cost of alterations to the insured person's principal residence to make it wheelchair accessible and habitable; and
- the one-time cost of modifications necessary to a motor vehicle utilised by the insured person to make the vehicle accessible or driveable for the insured person.

Benefit payments herein will not be paid unless:

- home alterations are made by a person or persons experienced in such alterations and recommended by a recognised organisation, providing support and assistance to wheelchair user; and
- vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the provincial vehicle licensing authorities.

The combined maximum payable will not exceed \$10,000.

2.9 Seat Belt Benefit

In the event an insured person sustains an injury which results in a payment being made under the Schedule of Losses, the Principal Sum amount will be increased by ten percent if, at the time of the accident, the insured person was driving or riding in a vehicle and wearing a properly fastened seat belt.

Due proof of seat belt use must be provided as part of the written proof of loss.

"Vehicle" means a private passenger car, station wagon, van, or jeep-type automobile.

"Seat belt" means those belts that form a restraint system.

2.10 Special Education Benefit

If you (the employee) suffer loss of life in a covered accident while the policy is in force, CIGNA Life will pay, in addition to all other benefits payable, a "special education benefit" up to a maximum of \$5,000 per year, on behalf of any dependant child who, on the date of the accident, is enrolled as a full-time student in any institution of higher learning beyond the 12th or 13th grade level, or was at the 12th or 13th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the date of the accident.

The "special education benefit" is payable annually for a maximum of four consecutive annual payments but only if the dependant child continues his/her education as a full-time student in an institution of higher learning. If, at the time of

the accident, none of the dependant children qualify, CIGNA Life pays an additional benefit of \$2,500 to the designated beneficiary (ies).

3. Exclusions

The plan does not cover any loss, which is the result of:

- intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane;
- full-time, active duty in the armed forces;
- injury sustained while the insured person is performing any common, manual, or mechanical labour which may be construed as part of the insured person's regular duties for NAV CANADA;
- any accident which occurs during the period you (the employee) are required to live in another community, away from the work premises in the city of permanent assignment, for reasons of training or work assignments lasting longer than 60 days;
- acrobatic flying as defined by the Department of Transport;
- operations requiring a special permit or waiver from the Department of Transport even though granted, other than a permit waiver issued because of the territory to be flown over or landed upon; or
- crop dusting or spraying, seeding, fire fighting, sky writing, pipeline inspection, power-line inspection, aerial photography, exploration, racing, endurance test or exhibition stunt flying.

4. Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the benefits afforded you.

If your body has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which you were riding at the time of the accident it shall be presumed, subject to all other conditions of the policy, that you suffered a loss of life resulting from bodily injuries sustained in the accident and covered.

5. Termination of Coverage

Coverage terminates upon the earlier of termination/retirement or attainment of age 75.

6. Claims Procedure

In the event of a claim, notice of claim must be given to CIGNA Life within 30 days from the date of accident and subsequent proof of claim must be submitted to CIGNA Life within 90 days from the date of the accident.

A claim form can be obtained from the Pensions, Benefits, and Employee Health Programs Department.

Notes