NAV CANADA
BENEFITS ONLINE

Management Employee (closed plan)

Benefits Online provides the information you need to get the most from the benefit program offered to our Management employes. If you are not an eligible Management employee this information does not apply to you.

The information contained in this document is as accurate as possible; however, final interpretation is governed by the terms of official insurance contracts. In case of conflict between the content in this docuement and the relevant contract, the contract will prevail.

Plan	Contract #	Provider
Health Care Plan	#25298	**Sun Life Assurance Company of Canada** NAV CANADA is legally and financially responsible for the benefits provided under the Health Care Plan, Dental Care Plan and Health Spending account. Sun Life only acts as administrator of these plans on behalf of NAV CANADA
Dental Care Plan		
Critical Illness Insurance Plan	#105158	
Basic Life Insurance Plan	#101198	
Management Insurance Plan		
Long Term Disability Plan		
Business Travel Accidental Death and Dismemberment Insurance Plan	N/A	**AIG Insurance Company of Canada**

To contact us:

NAV CANADA – HR Employee Centre

HREC-CERH@navcanada.ca

1-888-774-4732

Sun Life Financial

1-800-361-6212

Allianz Global Assistance

In case of an out-of-province emergency in Canada and the US: 1-800-854-7589. From anywhere, call collect: 1-519-742-6768.

Table of Contents

Eligibility

All full-time or part-time employees are eligible to enroll in the NAV CANADA benefit plans:

	While receiving pay		While on leave without pay	
	Compulsory	Optional	Compulsory	Optional
Health Care Plan		✓		✓
Dental Care Plan	✓			✓
Critical Illness Insurance Plan		✓		✓
Long-Term Disability Insurance	✓			✓
Basic Life Insurance Plan	✓		✓	
Management Insurance Plan		✓		✓
Business Travel Accidental Death and Dismemberment Plan	✓			

When am I eligible?

If you are…	You are eligible…
A permanent employee	The date you are appointed
An employee hired for at least six months	The date you are appointed
An employee hired for a term of six months or less, then appointed to another term of six months or less	The date after you complete six months of continuous employment
An employee hired for a term of six months or less, then appointed to another term of six months or more	The date of your new appointment begins

HEALTH CARE PLAN

All full-time or part-time NAV CANADA employees living in Canada with provincial health coverage can join the Health Care Plan. Enrolment is not automatic, you must request coverage within 90 days of becoming eligible, otherwise a three-month waiting period applies.

Coverage under the Health Care Plan includes the following:

- Health Practitioner
- Health Spending Account
- Hearing Aids
- Hospital and Ambulance
- Medical Supplies and Services
- Prescription Drugs
- Travel
- Vision Care

Examples

If you are appointed for an indeterminate period, you are eligible the date you are appointed:

	Example #1	Example #2
Date of appointment	Jun 7, 2020	Jun 7, 2020
Eligible to join	Jun 7, 2020	Jun 7, 2020
Application and proof of eligibility documents received	Jul 7, 2020	Oct 13, 2020
Coverage begins	Aug 1, 2020	Feb 1, 2021

If you are appointed for a term of more than 6 months you are eligible the date you are appointed:

	Example #1	Example #2
Term period	Jun 7, 2020 – Nov 7, 2021	Jun 7, 2020 – Nov 7, 2021
Eligible to join	Jun 7, 2020	Jun 7, 2020
Application and proof of eligibility documents received	Jul 7, 2020	Oct 13, 2020
Coverage begins	Aug 1, 2020	Feb 1, 2021

If you are appointed for a term of 6 months or less, and then appointed to another term of less than six months you are eligible the day after you complete six months of continuous employment:

	Example #1	Example #2
First term period	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Apr 7, 2021	Nov 8, 2020 – Apr 7, 2021
Eligible to join	Dec 7, 2020	Dec 7, 2020
Application and proof of eligibility documents received	Jan 7, 2021	Mar 13, 2021
Coverage begins	Feb 1, 2021	Not eligible, unless appointed to another term

If you are appointed for a term of 6 months or less, and then appointed to another term of six months or more you are eligible the date your new appointment begins:

	Example #1	Example #2
First term period	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Nov 8, 2021	Nov 8, 2020 – Nov 8, 2021
Eligible to join	Nov 8, 2020	Nov 8, 2020
Application and proof of eligibility documents received	Dec 15, 2020	Mar 13, 2021
Coverage begins	Jan 1, 2021	Not eligible, unless appointed to another term

Family Coverage

If you have enrolled in family coverage in the Health Care Plan to cover your spouse and children, their coverage begins when your coverage begins if the applicable supporting documents have been provided and approved.

If you are enrolled in single coverage and you get married, or change to common-law status with your spouse, or a child is added to your family, you can apply to change to family Health Care Plan coverage with the applicable supporting documents:

- within 90 days of the date of the change, coverage takes effect on the date of the change, or
- more than 90 days later, coverage takes effect on the first day of the fourth month after the application is received.

DENTAL CARE PLAN

All full-time or part-time NAV CANADA employees are eligible to join the Dental Care Plan. For Dental Care coverage enrolment is automatic on the date of eligibility and there is a waiting period of 3 months of continuous employment.

Examples

If you are appointed for an indeterminate period:

	Example
Date of appointment	Jun 7, 2020
Eligible to join	Jun 7, 2020
Coverage begins	Sept 7, 2020

If you are appointed for a term of more than 6 months:

	Example
Term period	Jun 7, 2020 – Feb 7, 2021
Eligible to join	Jun 7, 2020
Coverage begins	Sept 7, 2020

If you are appointed for a term of 6 months or less, and then appointed to another term of less than six months you are eligible the day after you complete six months of continuous employment:

	Example
First term period	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Apr 15, 2021
Eligible to join	Dec 7, 2020
Coverage begins	Mar 7, 2021

If you are appointed for a term of 6 months or less, and then appointed to another term of six months or more you are eligible the date your new appointment begins:

	Example
First term period	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Nov 8, 2021
Eligible to join	Nov 8, 2020
Coverage begins	Feb 8, 2021

CRITICAL ILLNESS INSURANCE

Management employees, under age 70 can join the Critical Illness Insurance Plan. The spouse, under age 70, and children of covered employees, who are under age 70, can also join the Critical Illness Insurance Plan.

You must enroll in Critical Illness Insurance as it is not automatic. If you enroll in Critical Illness Insurance within 31 days of eligibility proof of insurability is not required for the first $50,000 of coverage.

You are no longer eligible for Critical Illness Insurance coverage the earlier of:

- the date you retire;
- the date you reach age 70;
- the date a Critical Illness benefit is paid for a covered condition which you sustain;
- the date you are no longer a resident of Canada;
- the date of your death, or
- the date your employment ends with NAV CANADA, unless you choose to convert your coverage up to $100,000 to an individual policy with Sun Life.

Your spouse is no longer eligible for Critical Illness Insurance coverage the earlier of:

- the date you retire;
- the date you reach age 70;
- the date your spouse reaches age 70;
- the date your spouse ceases to be an eligible spouse;
- the date a Critical Illness benefit is paid for a covered condition which your spouse sustains;
- the date your spouse is no longer a resident of Canada;
- the date of your or your spouse’s death, or
- the date your employment ends with NAV CANADA, unless you choose to convert your spouse’s coverage up to $100,000 to an individual policy with Sun Life.

Your child is no longer eligible for Critical Illness Insurance coverage the earlier of:

- the date you retire;
- the date you reach age 70;
- the date your child ceases to be an eligible child;

- the date a Critical Illness benefit is paid for a covered condition which your child sustains (coverage will continue for the rest of your insured children);
- the date your child is no longer a resident of Canada;
- the date of your or your child's death; or
- the date your employment ends with NAV CANADA.

Examples

If you are appointed for an indeterminate period, you are eligible the date you are appointed:

	Example #1	Example #2	Example #3
Date of appointment	Jun 7, 2020	Jun 7, 2020	Jun 7, 2020
Eligible to join	Jun 7, 2020	Jun 7, 2020	Jun 7, 2020
Application received	Jul 1, 2020 (for coverage of $50,000 or less)	Jul 1, 2020 (for coverage of more than $50,000)	Jul 17, 2020
Coverage begins	Jul 1, 2020	When Sun Life approves the application	When Sun Life approves the application

If you are appointed for a term of more than 6 months you are eligible the date you are appointed:

	Example #1	Example #2	Example #3
Term period	Jun 7, 2020 – Apr 7, 2021	Jun 7, 2020 – Apr 7, 2021	Jun 7, 2020 – Apr 7, 2021
Eligible to join	Jun 7, 2020	Jun 7, 2020	Jun 7, 2020
Application received	Jul 1, 2020 (for coverage of $50,000 or less)	Jul 1, 2020 (for coverage of more than $50,000)	Jul 17, 2020
Coverage begins	Jul 1, 2020	When Sun Life approves the application	When Sun Life approves the application

If you are appointed for a term of 6 months or less, and then appointed to another term of less than six months you are eligible the day after you complete six months of continuous employment:

	Example #1	Example #2	Example #3
First term period	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Apr 7, 2021	Nov 8, 2020 – Apr 7, 2021	Nov 8, 2020 – Apr 7, 2021
Eligible to join	Dec 7, 2020	Dec 7, 2020	Dec 7, 2020
Application received	Jan 3, 2021 (for coverage of $50,000 or less)	Jan 3, 2021 (for coverage of more than $50,000)	Feb 13, 2021
Coverage begins	Jan 3, 2021	When Sun Life approves the application	When Sun Life approves the application

If you are appointed for a term of 6 months or less, and then appointed to another term of six months or more you are eligible the date your new appointment begins:

	Example #1	Example #2	Example #3
First term period	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Nov 8, 2021	Nov 8, 2020 – Nov 8, 2021	Nov 8, 2020 – Nov 8, 2021
Eligible to join	Nov 8, 2020	Nov 8, 2020	Nov 8, 2020
Application received	Dec 3, 2020 (for coverage of $50,000 or less)	Dec 3, 2020 (for coverage of more than $50,000)	Jan 14, 2021
Coverage begins	Dec 3, 2020	When Sun Life approves the application	When Sun Life approves the application

BASIC LIFE INSURANCE PLAN

All full-time or part-time employees are eligible to join the Basic Life Insurance Plan. Enrolment in the Basic Life Insurance Plan is automatic on the date the employee becomes eligible as long as you meet the actively at work criteria.

Examples

If you are appointed for an indeterminate period:

	Example
Date of appointment	Jun 7, 2020
Eligible to join	Jun 7, 2020
Coverage begins	Jun 7, 2020

If you are appointed for a term of more than 6 months:

	Example
Term period	Jun 7, 2020 – Feb 7, 2021
Eligible to join	Jun 7, 2020
Coverage begins	Jun 7, 2020

If you are appointed for a term of 6 months or less, and then appointed to another term of less than six months you are eligible the day after you complete six months of continuous employment:

	Example
First term period	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – May 15, 2021
Eligible to join	Dec 7, 2020
Coverage begins	Dec 7, 2020

If you are appointed for a term of 6 months or less, and then appointed to another term of six months or more you are eligible the date your new appointment begins:

	Example
First term period	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Nov 8, 2021
Eligible to join	Nov 8, 2020
Coverage begins	Nov 8, 2020

LONG-TERM DISABILITY INSURANCE PLAN

All full-time or part-time NAV CANADA employees are eligible to join the Long-Term Disability Insurance Plan. Enrolment in the Long-Term Disability Insurance Plan is automatic on the date you become eligible.

You are no longer eligible for Long-Term Disability Insurance coverage on the first day of the elimination period prior to the day you reach age 65.

Examples

If you are appointed for an indeterminate period:

	Example
Date of appointment	Jun 7, 2020
Eligible to join	Jun 7, 2020
Coverage begins	Jun 7, 2020

If you are appointed for a term of more than 6 months:

	Example
Term period	Jun 7, 2020 – Feb 7, 2021
Eligible to join	Jun 7, 2020
Coverage begins	Jun 7, 2020

If you are appointed for a term of 6 months or less, and then appointed to another term of less than six months you are eligible the day after you complete six months of continuous employment:

	Example
First term period	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – May 15, 2021
Eligible to join	Dec 7, 2020
Coverage begins	Dec 7, 2020

If you are appointed for a term of 6 months or less, and then appointed to another term of six months or more you are eligible the date your new appointment begins:

	Example
First term period	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Nov 8, 2021
Eligible to join	Nov 8, 2020
Coverage begins	Nov 8, 2020

MANAGEMENT INSURANCE PLAN

All full-time or part-time Management employees can apply for coverage under the Management Insurance Plan.

Coverage under the Management Insurance* Plan includes the following:

- Supplemental Life Insurance
- Optional Life Insurance**
- Accidental Death and Dismemberment Insurance
- Dependent Insurance

**This optional plan consists of four components. You must enroll in Supplemental Life Insurance to apply for the other plans.*

***You must provide evidence of insurability to enroll; coverage begins when Sun Life Financial approves your application.*

If you enroll in Supplemental Life Insurance, Dependent Insurance or Accidental Death and Dismemberment Insurance within 60 days of becoming eligible proof of eligibility is not required. Proof of eligibility is required for Optional Life Insurance.

Examples

If you are appointed for an indeterminate period, you are eligible the date you are appointed:

	Example #1	Example #2	Example #3
Date of appointment	Jun 7, 2020	Jun 7, 2020	Jun 7, 2020
Eligible to join	Jun 7, 2020	Jun 7, 2020	Jun 7, 2020
Application received	Jul 13, 2020 (for all plans)	Jul 13, 2020 (for Optional Life Insurance)	Aug 12, 2020 (for all plans)
Coverage begins	Jul 13, 2020 (except for Optional Life Insurance)	When Sun Life approves the application	When Sun Life approves the application

If you are appointed for a term of more than 6 months you are eligible the date you are appointed:

	Example #1	Example #2	Example #3
Term period	Jun 7, 2020 – Nov 7, 2021	Jun 7, 2020 – Nov 7, 2021	Jun 7, 2020 – Nov 7, 2021
Eligible to join	Jun 7, 2020	Jun 7, 2020	Jun 7, 2020
Application received	Jul 13, 2020 (for all plans)	Jul 13, 2020 (for Optional Life Insurance)	Aug 13, 2020 (for all plans)
Coverage begins	Jul 13, 2020 (except for Optional Life Insurance)	When Sun Life approves the application	When Sun Life approves the application

If you are appointed for a term of 6 months or less, and then appointed to another term of less than six months you are eligible the day after you complete six months of continuous employment:

	Example #1	Example #2	Example #3
First term period	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Apr 7, 2021	Nov 8, 2020 – Apr 7, 2021	Nov 8, 2020 – Apr 7, 2021
Eligible to join	Dec 7, 2020	Dec 7, 2020	Dec 7, 2020
Application received	Dec 15, 2020 (for all plans)	Dec 15, 2020 (for Optional Life Insurance)	Feb 12, 2021 (for all plans)
Coverage begins	Dec 15, 2020 (except for Optional Life Insurance)	When Sun Life approves the application	When Sun Life approves the application

If you are appointed for a term of 6 months or less, and then appointed to another term of six months or more you are eligible the date your new appointment begins:

	Example #1	Example #2	Example #3
First term period	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020	Jun 7, 2020 – Nov 7, 2020
Second term period	Nov 8, 2020 – Nov 8, 2021	Nov 8, 2020 – Nov 8, 2021	Nov 8, 2020 – Nov 8, 2021
Eligible to join	Dec 8, 2020	Dec 8, 2020	Dec 8, 2020
Application received	Nov 15, 2020 (for all plans)	Nov 15, 2020 (for Optional Life Insurance)	Jan 15, 2021 (for all plans)
Coverage begins	Nov 15, 2020 (except for Optional Life Insurance)	When Sun Life approves the application	When Sun Life approves the application

BUSINESS TRAVEL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

All active employees under age 75 who live in Canada and are travelling for business are covered under the Business Travel Accidental Death and Dismemberment Insurance plan.

Your spouse, under age 75, and children are also covered during relocation or related house-hunting trip.

FREQUENTLY ASKED QUESTIONS

Is my family eligible for benefits?

Supporting documents as defined below must be provided to and approved by the HR Employee Centre (HREC) before family coverage under the Health Care and Dental Care Plans can be in effect.

- Spouse: Birth certificate of spouse and marriage certificate
- Common law: Birth certificate of common law partner and statutory declaration
- Child: Birth certificate
- Foster Child: Birth certificate and legal guardianship documentation
- Adopted Child: Birth certificate and legal guardianship documentation (if not indicated on birth certificate)
- Stepchild: Birth certificate (will only be eligible if spouse/common-law approved)

You may choose family coverage under the Health Care and Dental Care Plans to cover your spouse and children, once they meet the plans' definitions and proof of eligibility has been provided. Only one spouse may be covered at one time. You can obtain coverage for your spouse and children under the Dependent Insurance Plan as well as under the Critical Illness Insurance Plan.

In the event of your death, your surviving spouse who is eligible for a pension from the NAV CANADA Pension Plan, can join the Health Care Plan once his or her pension becomes payable.

What if I am not at work the day my coverage is supposed to start?
Coverage cannot begin when you are not considered to be actively at work.

Being at work for the Basic Life Insurance, Management Insurance and the Long-term Disability Insurance Plans, means:

- not disabled and:
  - actually working at NAV CANADA,
  - assigned elsewhere by NAV CANADA, or
  - away for vacation, a weekend or statutory holiday, or shift variance.

Being at work for the Health Care Plan, Dental Care Plan and Critical Illness Insurance Plan means:

- performing the usual duties of your job or, if on a scheduled workday off, at work on your last scheduled workday.

How do I know for sure that I have Health or Dental Care coverage?
Contact the HR Employee Centre.

What if I lose or damage my benefit card?
You can visit the Sun Life Financial web site at www.mysunlife.ca/NAVCANADA and enter your Access ID and password to access your benefit information under the Health Care Plan and/or Dental Care Plan. To obtain your Access ID, contact a Sun Life Financial Customer Care representative at 1-800-361-6212. The contract number (25298) and your member certificate number (provided by the HR Employee Centre) will be required.

Once on the site, you must click on the “take me to” drop down menu in the center of the page. Choose and click on “print a drug card”. An image of the drug card will appear on screen. Simply print as many copies as you require.

Can I change from single to family coverage under the Health Care Plan or vice versa? How?
Yes. Contact the HR Employee Centre within 90 days of marriage, change to common-law status, or birth of child and coverage takes effect the date of the event (subject to approval of proof of eligibility documents). If you miss that deadline, the change takes effect on the first day of the fourth month after the application is received.

When changing from family to single coverage, the effective date of the change will be no later than 60 days following receipt of the application.

Can I cancel coverage?

You cannot cancel compulsory coverage.

For optional coverage, you can cancel anytime. However, if you wish to reapply later, some restrictions may apply.

To cancel Health Care coverage, you must contact the HR Employee Centre.

Life Events

JOINING NAV CANADA

When you become eligible, the HR Employee Centre (HREC) will give you the forms you need to take advantage of the Benefit Plans that apply to you as a management employee:

- Health Care Plan, including:
  - Supplementary coverage, when you live in Canada and are covered by a provincial health plan, and
  - Annual Health Spending Account of $750 (prorated for the first year if your coverage begins after March 31), which can be used to claim any health or dental expenses eligible under the Income Tax Act (section 118.2(2)) for you and your dependent(s);
- Dental Care Plan;
- Long Term Disability Insurance Plan;
- Basic Life Insurance Plan;
- Management Insurance Plan, including:
  - Supplemental Life Insurance;
  - Optional Life Insurance;
  - Accidental Death and Dismemberment Insurance; and
  - Dependent Insurance.
- Critical Illness Insurance; and
- Business Travel Accidental Death and Dismemberment Insurance.

Coverage start dates vary by plan:

Benefit	If...	Coverage starts...
Health Care Plan: Supplementary Coverage	Your application and proof of eligibility are received within 90 days of the date you become eligible	The first day of the month after the application and documentation are received
	Your application and proof of eligibility are received within 90 days of the date you become eligible	The first day of the fourth month after the application and documentation are received
Health Care Plan: Health Spending Account	You are eligible	The same date as your Health Care Plan coverage

Benefit	If...	Coverage starts...
Dental Care Plan	You are eligible	After a waiting period of exactly 3 months of continuous employment
Long-Term Disability	You are eligible	Immediately
Basic Life Insurance	You are eligible	Immediately
Management Insurance Plan: Supplemental Life Insurance, Dependent Insurance, and Accidental Death and Dismemberment Insurance **You must enroll in Supplemental Life Insurance to join any other plan.*	Your application is received within 60 days of the date you become eligible	The date you: • become eligible, or • your application is received by the Payroll Section, whichever is later
	You apply more than 60 days after you become eligible	When Sun Life Financial approves your application, with evidence of insurability
Management Insurance Plan: Optional Life Insurance	You apply any time after you become eligible	When Sun Life Financial approves your application, with evidence of insurability
Critical Illness Insurance Plan	Your application for coverage of $50,000 or less is received within 31 days of the date you become eligible	The date you: • become eligible, or • your application is received by the Payroll Section, whichever is later
	Your application is received more than 31 days after you become eligible or you are applying for coverage of more than $50,000	When Sun Life Financial approves your application, with evidence of insurability
Business Travel Accidental Death & Dismemberment Insurance		The date you start a trip on NAV CANADA business from your place of employment, home or other location

*You must enroll in Supplemental Life Insurance to join any other plan.

Family Coverage

If you have enrolled in family coverage in the Health Care and Dental Care Plans to cover your spouse and children, their coverage begins when your coverage begins if the applicable supporting documents have been provided to the HR Employee Centre and approved.

If you are enrolled in single coverage and you get married, or change to common-law status with your spouse, or a child is added to your family, you can apply to change to family coverage with the applicable supporting documents:

- within 90 days of the date of the change, coverage takes effect on the date of the change, or
- more than 90 days later, coverage takes effect on the first day of the fourth month after the application is received.

LEAVING NAV CANADA

In general, coverage ends if you leave NAV CANADA for a reason other than retirement:

Plan	When Coverage Ends
Health Care Plan	The end of the month following your last day of employment with NAV CANADA
Dental Care Plan	The last day of employment at NAV CANADA
Long Term Disability Insurance	
Basic Life Insurance	
Management Insurance Plan	
Business Travel Accidental Death and Dismemberment Insurance	

You cannot continue your coverage under the Health Care, Dental Care, Long Term Disability Insurance or Business Travel Accidental Death and Dismemberment Insurance Plans once you leave.

Health Care Plan

You may benefit from “My Health Choice” package offered by Sun Life. To be eligible:

- you and everyone included in your application must be age 75 or less on the date you apply,
- you must be covered under a provincial health care plan,
- children age 21 to 25 (26 for Quebec residents) must be full-time students at college or university,
- you must be a Canadian resident, and
- you must apply no more than 60 days after your NAV CANADA coverage ends.

For more information:

- Visit www.sunlife.ca/healthreplacement. You will find everything you need, from plan details to application forms. You can even purchase coverage directly online.
- Call toll-free 1-800-SUN LIFE (1-800-786-5433). If you are interested, but do not have Internet access, the Customer Care Centre will send you an application form. Once approved, Sun Life will send you a welcome package with detailed coverage information.
- Contact Sun Life by e-mail at healthsolutions@sunlife.com.
- Finally, you can print and complete the Health Coverage Choice Application Form here.

If you are an employee covered under the Health Care Plan, you will have 90 days after your coverage ends to submit claims for reimbursement eligible expenses under the Plan or your Health Spending Account. Expenses must have been incurred, that is, they must be dated before your coverage end date; otherwise, they will be rejected.

Basic Life Insurance Plan

If you leave NAV CANADA and defer your pension, you can maintain your coverage. Just send a written request to the HR Employee Centre (HREC) with a cheque for the first 12-month payment no more than 30 days after your termination date. You will be covered for the same amount as when you left NAV CANADA if you were under age 61; coverage begins to reduce as of your 61st birthday. The coverage reduces to $0 at age 70 (the minimum coverage of $5,000 does not apply).

If you leave NAV CANADA and transfer the value of your pension benefits out of the NAV CANADA Pension Plan, you can continue coverage by applying for conversion to a private policy with Sun Life no more than 31 days after you leave. If you choose this option, you pay your premiums directly to Sun Life.

Converting Life Insurance

Within 31 days of leaving NAV CANADA, you can contact Sun Life directly to buy individual life insurance without a medical examination (regardless of your state of health), subject to certain restrictions. You can also convert your spouse's life insurance. You cannot, though, convert your children's Dependent Insurance or your Accidental Death and Dismemberment Insurance.

If you die during the 31-day period after you leave NAV CANADA, benefits will be paid as if you had converted coverage, even if you had not.

Extension of Benefits

Health Care Plan coverage continues:

- for charges related to pregnancy and delivery, until the end of the month in which the pregnancy is terminated or the end of the month in which the child is born, where a member dies leaving a widow who is pregnant and who was a covered dependent at the time of the member's death and the widow is not in receipt of a pension, she may continue her coverage by the payment of the total required contribution.

Dental Care Plan coverage continues:

- for completion of certain dental treatments (for example, root canal treatment where the pulp chamber is opened) started before coverage ended, as long as work is completed within 31 calendar days from the end of coverage, and
- to the end of the calendar quarter that includes the month coverage ends, for eligible orthodontic services of a child, that began before coverage ended.

Retiring

You cannot continue your coverage under the Dental Care, Long-Term Disability Insurance or Business Travel Accidental Death and Dismemberment Insurance Plans once you retire from NAV CANADA.

Check the definition of retiree in the glossary section to determine if you are an eligible retiree. If you are, you may opt for Health Care of Basic Life Insurance coverage during your retirement. Please refer to the Management Retiree profile as each plan has a strict application deadline for coverage. If your application is not received within the deadline provided, coverage will be declined.

The Health Spending Account is not offered to retirees, even if you continue your Health Care Plan coverage when you retire. You must submit final claims under your Health Spending Account no more than 90 days after your coverage as an employee ends. Expenses must have been incurred, that is, the receipts must be dated before your coverage end date; otherwise, they will be rejected.

Any required cost is deducted from your pension. If your premiums are higher than your pension amount, you must send a cheque for the required premium in advance to the HR Employee Centre (HREC).

Refer to the Management Retiree Profile for further information.

Critical Illness Insurance Plan

If you leave NAV CANADA before age 70, you can maintain your coverage without having to provide proof of good health by converting your coverage to an individual policy no more then 31 days after your termination date, subject to certain restrictions. You can also convert your spouse's Critical Illness insurance. You can convert the current coverage up to a maximum of $100,000. If you choose this option, you pay your premiums directly to Sun Life based on their commercial rates. Converted coverage also ends at age 70. This option is not available for Child Critical Illness insurance.

For more information call toll-free 1-800-SUN LIFE (1-800-786-5433).

Converting Management Insurance Plan

Within 31 days of leaving NAV CANADA, you can contact Sun Life directly to buy individual life insurance for the Supplemental and Optional Life Insurance without a medical examination (regardless of your state of health), subject to certain restrictions. You can also convert your spouse's life insurance. You cannot, though, convert your children's Dependent Insurance or your Accidental Death and Dismemberment Insurance.

If you die during the 31-day period after you leave NAV CANADA, benefits will be paid as if you had converted coverage, even if you had not.

CHANGING POSITIONS OR EARNINGS

Transferring from Represented to Management (vice-versa)

If you transfer from a represented to a management full-time or part-time position, you become eligible for the Management Insurance Plan and all management coverage and premium cost-sharing. Vice-versa, your management coverage and premium cost-sharing ends, but you can maintain the coverage you have under the Management Insurance Plan.

Changing from Part-time to Full-time (vice-versa)

If you were working less than one-third of a full-time equivalent position, you may become eligible for new or revised coverage when you start working full-time. If you transfer to a position working less than one-third of a full-time equivalent position, your coverage ends.

Change in Earnings

Any increase or decrease in your annual earnings, resulting from earnings rate adjustments, increments, and promotions, means a corresponding change in the amount of life and accident, business travel, and disability coverage, depending on the plans for which you are eligible.

Life insurance amounts and premiums are revised on the effective date of the change.

If your earnings increase retroactively or decrease before the effective date, coverage changes the first of the month following the month in which the change is authorized. Here is an example of how this works for Basic Life Insurance coverage.

Annual earnings	$62,950
Adjusted insurable earnings	$126,000
Management Salary Program	October 24, 2020
Retroactive to	September 1, 2020
Coverage Increases	November 1, 2020

For disability coverage, retroactive salary increases affect your benefits only if the increase date falls before you began to receive disability benefits.

TAKING AN AUTHORIZED LEAVE OF ABSENCE

During paid leave, benefits coverage continues as though you were at work.

On unpaid leave for:

- illness or disability,
- maternity, adoption or paternity,
- education,
- service with an international organization,
- relocation of your spouse, or
- personal reasons.

You have the option to continue the Management Insurance Plan coverage as well as Critical Illness Insurance as long as you pay the required premiums before your leave starts. You can give post-dated cheques or make a lump-sum payment. Should you choose not to continue coverage, you will be subject to a health assessment upon re-enrolment.

If your leave is for:

- education,
- relocation of your spouse, or
- personal reasons

You will have to pay both the employee and employer portion of the required premiums for all the NAV CANADA Benefit Plans you want to maintain beyond the first three months of leave, (please note that the Basic Life Insurance is not optional) as long as you pay the required premiums before your leave starts. You can give post-dated cheques or make a lump-sum payment.

If you become disabled while on leave and have maintained your disability coverage, you would be entitled to short-term disability. Long-Term disability benefits would begin following the expiration of short-term disability benefits. If you choose not to continue your Long-Term Disability coverage any disability arising during this period will not be eligible for coverage once you return to work.

CHANGE IN MARITAL STATUS

- Check the definition of spouse in the glossary section to determine if your new spouse is eligible.
- Apply to change your Health Care Plan coverage to family, if you had single.
    - You must provide the applicable proof of eligibility to the HR Employee Centre (HREC). You must update the NAV Employee Self Serve account to show Family Health Care coverage and add your spouse as a dependent.
    - If you apply within 90 days of your marriage, or your change in status with a common-law spouse after one year of cohabitation, coverage takes effect on the date of the change.
    - If you apply more than 90 days later, coverage takes effect the first day of the fourth month after your application is received.
- Apply to change your Health Care Plan coverage to single, if you had family coverage and you have no other eligible dependents. Your coverage change takes effect no more than 90 days after you update the NAV Employee Self Serve account to show single Health Care coverage. If you have other dependents, you must update the NAV Employee Self Serve account to uncover your spouse from the Health Care and Dental Care plans.
- Change your designated beneficiary, if you wish and are permitted to do so by law by submitting the applicable form. Updating your dependents for Health and Dental Care coverage in no way changes your beneficiary for life insurance.
- Enrol in or cancel your Dependent Insurance, if you wish.
- You can apply to cover your spouse under the Critical Illness Insurance, proof of good health is required for your spouse.

ADDING A CHILD TO YOUR FAMILY

Check the definition of child in the glossary section to determine if your new child is eligible.

Apply to change your Health Care Plan coverage to family, if you had single coverage:

- You must provide the applicable proof of eligibility to the HR Employee Centre (HREC). You must update the NAV Employee Self Serve account to show Family Health Care coverage and to add your child as a dependent.
- If you apply within 90 days of the arrival of the child, coverage takes effect on the date of the change.
- If you apply more than 90 days later, coverage takes effect the first day of the fourth month after your application is received.

Change your designated beneficiary, if you wish and are permitted to do so by law, by submitting the applicable form. Updating your dependents for Health and Dental Care coverage in no way changes your beneficiary for life insurance.

Adding a child to your Critical Illness Insurance

- You can apply to cover your children under the Critical Illness Insurance.
- You cannot apply for Child Critical Illness coverage until you have children who are living.
- Either you or your spouse must have Critical Illness coverage in order to obtain coverage for your eligible children.
- Children may be subject to either the Child moratorium period exclusion or the Pre-existing conditions provision as described in the Critical Illness section. When applicable, the Child moratorium period exclusion and the Pre-existing conditions provision apply to all covered conditions for which the child is covered.
- For children:
    - who are the children of you or your spouse and are born during the period beginning 90 days prior to the date you become covered for Child Critical Illness and ending 10 months after such date, the Child moratorium period exclusion applies.
    - who are the children of you or your spouse and are born or adopted later than 10 months after the date you become covered for Child Critical Illness, neither the Child moratorium period exclusion or the Pre-existing conditions provision apply.
    - other than those described above, the Pre-existing conditions provision applies unless proof of good health is required for the child's coverage.
- If you already have a child covered under this plan all new children become automatically enrolled.

CHILD REACHES AGE 21

If your child is not attending an accredited school full-time, Health Care and Dental Care coverage ends when he or she reaches age 21. If your child enters a spousal relationship before that date, coverage ends immediately.

If your child depends on you for support because of a psychiatric or physical disability and became disabled before age 21, coverage may continue without age limit. You must complete the Disabled Child Coverage Form and submit to Sun Life Financial for approval prior to your child's 21st birthday to benefit from continued coverage beyond age 21.

NAV CANADA will only be advised if the application has been approved in order to maintain your child’s coverage. Information related to the diagnosis of your child will not be released to NAV CANADA.

It is your responsibility to cancel your Dependent Insurance coverage. To do so, complete the Management Insurance Plan Application Form. Otherwise, premiums will continue to be deducted until you cancel the coverage or leave NAV CANADA, whichever happens last.

CHILD GOING TO/LEAVING COLLEGE OR UNIVERSITY

Child going to school or university

Coverage continues until age 25 (age 26, for Quebec residents) as long as your child is enrolled in an accredited school full-time and a letter or other confirmation of your child's enrolment is provided to the HR Employee Centre (HREC) on an annual basis. You must update the NAV Employee Self Serve account to update the Student Status of your child. The Student Status field will need to be updated annually.

For Dependent Insurance, attending school includes time when enrolled but absent from school or university because of vacation or physical impairment, or temporary training outside the school/university.

Child leaving school or university

Coverage ends if your child is older than age 21 and stops attending school full-time.

For Dependent Insurance, attending school includes time when enrolled but absent from school or university because of vacation or physical impairment, or temporary training outside the school/university.

It is your responsibility to cancel your Dependent Insurance coverage. To do so, complete the Management Insurance Plan Application Form. Otherwise, premiums will continue to be deducted until you cancel the coverage or leave NAV CANADA, whichever happens last.

BOTH SPOUSES WORKING AT NAV CANADA

Health Care Plan	You may both apply for family coverage, and both cover your children. Co-ordination of benefits is permitted.
Dental Care Plan	
Business Travel Accidental Death and Dismemberment Insurance	You spouse and children are covered during relocation and related house-hunting trip.
Critical Illness Insurance	You may both insure each other and your children.
Dependent Insurance	

CHANGING PERSONAL INFORMATION

To change your personal information, please log in to your Workday account and follow these steps:

1. Click on the "Personal Information" icon
2. In the "Change" column on the left, choose the information that needs to be updated.

This Workday job aid can assist you in making any updates necessary.

Costs / Premiums

All premium rates are subject to change based on the experience of the plans.

HEALTH CARE PLAN

The monthly premiums for the Health Care Plan are as follows:

Employees pay...		NAV CANADA pays...	
Single Coverage	Family Coverage	Single Coverage	Family coverage
$0	$0	$111.06	$240.23

Premiums are subject to provincial tax: for Ontario and Quebec (9%).

For Quebec residents, premiums and provincial tax paid by NAV CANADA for your Health Care Plan coverage are subject to provincial income tax. This annual taxable benefit is reported on your Relevé 1 or Relevé 2 (but not your T4 or T4A). If you live in Quebec and work in another province you will not receive a Relevé 1 slip. These amounts will be reported in a separate letter, which will be distributed at the same time as the T4 slips. If you live and work in Quebec, these benefits will be reported in Box A and Box J of the Relevé 1 slip.

DENTAL CARE PLAN

The monthly premiums for the Dental Care Plan are as follows:

Employees pay...	NAV CANADA pays...
$0	$106.58

On certain types of leave without pay the monthly premiums for the Dental Care Plan are as follows:

	Employees pay...	NAV CANADA pays...
Employees without dependents	$45.84	$0
Employees with dependents	$106.58	$0

Premiums are subject to provincial tax: for Ontario and Quebec.

For Quebec residents, premiums and provincial tax paid by NAV CANADA for your Dental Care Plan coverage are subject to provincial income tax. This annual taxable benefit is reported on your Relevé 1 or Relevé 2 (but not your T4 or T4A). If you live in Quebec and work in another province you will not receive a Relevé 1 slip. These amounts will be reported in a separate letter, which will be distributed at the same time as the T4 slips. If you live and work in Quebec, these benefits will be reported in Box A and Box J of the Relevé 1 slip.

CRITICAL ILLNESS INSURANCE

The monthly premiums for Critical Illness Insurance are as follows:

Employees pay...	NAV CANADA pays...
The premium indicated in the following table, based on the insured's gender and age per $25,000 of coverage*	$0

Premiums are subject to provincial tax: for Ontario, Quebec, and Manitoba.

Monthly premium per $25,000 of coverage per insured:

	Non Smoker		Smoker	
Age group	**Male**	**Female**	**Male**	**Female**
Up to 29	$3.00	$2.83	$3.54	$3.33
30-34	$4.15	$4.94	$5.73	$6.60
35-39	$5.08	$6.09	$7.32	$9.41
40-44	$7.43	$8.22	$12.46	$14.98
45-49	$12.18	$11.53	$24.13	$23.55
50-54	$19.55	$15.38	$44.33	$32.88
55-59	$30.57	$20.48	$74.22	$42.60
60-64	$50.02	$28.84	$118.51	$54.56
65-69	$95.50	$49.51	$207.06	$85.91

Monthly Premium for Child Critical Illness Insurance per $25,000 of coverage:

Employees pay...	NAV CANADA pays...
$2.26 per $25,000 of coverage, regardless of the number of children covered	$0

Example:

Province of residence	Ontario
Province of work	Ontario
Gender	Male
Age	40
Coverage	$200,000
Smoker Status	Non smoker
Employee's monthly premium	$6.75 x ($200,000/$25,000) = $54.00
Monthly premium plus provincial tax*	$54.00 + ($54.00 x 8%) = $58.32

*Since the employee lives in Ontario, there is an 8% provincial tax

BASIC LIFE INSURANCE

The monthly premiums for Basic Life Insurance are as follows:

Employees pay...	NAV CANADA pays...
$0	$0.176 per $1,000 of coverage

Premiums are subject to provincial tax: for Ontario, Quebec and Manitoba.

Life insurance premiums and provincial tax paid by NAV CANADA constitute a taxable benefit under the Income Tax Act. This amount is added to your T4 and Relevé 1 slips, for active employees. Applicable income tax is deducted from your pay. If you live in Quebec and work in another province you will not receive a Relevé 1 slip.

LONG-TERM DISABILITY INSURANCE

The monthly premiums for Long-Term Disability Insurance are as follows:

Employees pay...	NAV CANADA pays...
$0	$1.802per $1,000 of adjusted insurable earnings

Premiums are subject to provincial tax: for Ontario, Quebec and Manitoba.

MANAGEMENT INSURANCE PLAN

Supplemental Life Insurance

Monthly premiums for Supplemental Life Insurance are as follows:

	Employees pay...	NAV CANADA pays...
Senior Managers and Middle Managers	$0	$0.25 / $1,000 of adjusted insurable earnings
Management and Confidential Staff	The premium indicated in the following table, based on gender and age per $1,000 of adjusted insurable earnings*	$0

*Premiums are subject to provincial tax: for Ontario, Quebec and Manitoba.

Monthly premium per $1,000 of adjusted insurable earnings:

Age Group	Male	Female
30 and less	$0.05	$0.03
31-35	$0.05	$0.05
36-40	$0.08	$0.05
41-45	$0.12	$0.08
46-50	$0.20	$0.14
51-55	$0.33	$0.23
56-60	$0.52	$0.37
61-65*	$0.60	$0.41
66-70*	$0.31	$0.23
71-75*	$0.21	$0.17
76-80*	$0.33	$0.26

*Premium rates take reducing coverage into account.

Optional Life Insurance

Monthly premiums for Optional Life Insurance are as follows:

Employees pay...	NAV CANADA pays...
The premium indicated in the following table, based on gender and age per $1,000 of adjusted insurable earnings	$0

*Premiums are subject to provincial tax: for Ontario, Quebec and Manitoba.

Monthly premium per $1,000 of adjusted insurable earnings:

Age Group	Male	Female
30 and less	$0.04	$0.02
31-35	$0.04	$0.04
36-40	$0.05	$0.04
41-45	$0.08	$0.06
46-50	$0.13	$0.10
51-55	$0.23	$0.16
56-60	$0.35	$0.26
61-65*	$0.42	$0.29
66-70*	$0.21	$0.16
71-75*	$0.15	$0.12
76-80*	$0.24	$0.20

*Premium rates take reducing coverage into account.

Accidental Death & Dismemberment Insurance

Monthly premiums for Accidental Death and Dismemberment Insurance are as follows:

	Employees pay...	NAV CANADA pays...
Senior Managers	$0	$0.525 / unit of $25,000
Middle Managers, and Management and Confidential Staff	$0.20 / unit of $25,000	$0.125 / unit of $25,000

Effective September 1, 2015 the monthly premiums for Accidental Death and Dismemberment Insurance are as follows:

	Employees pay...	NAV CANADA pays...
Senior Managers	$0	$0.525 / unit of $25,000
Middle Managers, and Management and Confidential Staff	$0.325 / unit of $25,000	$0

*Premiums are subject to provincial tax: for Ontario, Quebec and Manitoba.

Dependent Insurance

Monthly premiums for Dependent Insurance are as follows:

	Employees pay...	NAV CANADA pays...
Senior Managers	$0	$1.00
Middle Managers, and Management and Confidential Staff	To cover your spouse only, or your spouse and children: • the premium indicated in the following table, based on your gender and age To cover your children only • $0.39 regardless of age, gender or number of children covered	$0

*Premiums are subject to provincial tax: for Ontario, Quebec and Manitoba.

Monthly premium based on employee's age and gender:

Age Group	Male	Female
26 and less	$0.39	$0.39
26-30	$0.48	$0.55
31-35	$0.63	$0.70
36-40	$0.79	$0.86
41-45	$0.86	$1.01
46-50	$1.01	$1.18
51-55	$1.18	$1.56
56-60	$1.56	$2.35
61-65	$2.35	$3.60
66-70	$1.18	$1.80
71-80	$1.80	$2.81

Example:

Province of residence	Ontario
Gender	Male
Level	MGR 1
Age	40
Salary	$95,000
Supplemental Life Coverage	$95,000
Optional Life Coverage	$95,000
Dependent Coverage	Spouse Only
Accidental Death and Dismemberment Coverage	$200,000 (8 units of $25,000)
Employee's monthly premium (Optional Life, Dependent Life and Accidental Death and Dismemberment Insurance)	$95,000 / $1,000 x $0.05 = $4.75 (Optional Life) $0.79 (Dependent Life) 8 units x $0.20 = $1.60 (AD&D Insurance)
NAV CANADA's monthly premium (Supplemental Life and Accidental Death and Dismemberment Insurance)	$95,000 / $1,000 x $0.25 = $23.75 (Supplemental Life Insurance) 8 units x $0.125 = $1.00 (AD&D Insurance)
Employee's monthly premium plus provincial tax*	$4.75 + $0.79 + $1.60 = $7.14 $7.14 x 8% = $7.71
NAV CANADA's monthly premium plus provincial tax*	$23.75 + $1.00 = $24.75 $24.75 x 8% = $26.73

*Since the employee lives and works in Ontario, there is an 8% provincial tax

Taxable Benefit

Life insurance premiums, accident insurance premiums and provincial tax paid by NAV CANADA constitute a taxable benefit under the Income Tax Act. This amount is added to your T4 and Relevé 1 slips. Applicable income tax is deducted from your pay.

BUSINESS TRAVEL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The Business Travel Accidental Death and Dismemberment Plan is offered to employees at no cost.

FREQUENTLY ASKED QUESTIONS

How do I pay my part of the cost?
By payroll deduction.

How do I pay if I am not getting a pay cheque?
With post-dated cheques, to cover the period of your leave without pay. You must provide these cheques before you leave.

What happens if the cost changes?
Your cost is adjusted as of the effective date of the change. The HREC will advise you of any changes to the rates, in advance. If you are on leave at the time, you make up the difference once you are back at work.

Prescription Drugs

WHAT'S COVERED?

Reasonable and customary charges for covered prescription drugs, as long as the medication is medically necessary for the treatment of disease or injury and approved by Sun Life.

90% brand name prescription drug cost only if a generic drug equivalent does not exist.

95% of lowest alternative generic prescription drug cost if one is approved on the market, except if your physician completes a medical exception form for consideration if the brand name drug is medically necessary; the exception request will be reviewed by Sun Life and a decision will be communicated in writing to pay 95% of the brand name cost.

Expenses with a maximum reimbursable amount will be paid at 100%.

Per Script Fee

$10 The plan will deduct a per script fee of $10 for each Drug Identification Number (DIN) claimed on an individual receipt if expense not purchased at a Preferred Pharmacy ($4 per script fee applies in Quebec, regardless of the pharmacy). You pay the remaining cost.

Dispensing Fees

Max 5 Maximum 5 dispensing fees per year for maintenance drugs (with the same DIN). This is called a Dispensing Fee Frequency Limit (DFFL). The DFFL is 5 times in a benefit year. Each group of maintenance drugs has its own DFFL as does each person under this plan. If a person fills a prescription more often than the drug's DFFL, dispensing fees incurred on claims that exceed the DFFL will not be eligible for reimbursement.

Prior Authorization Program

Specialty drugs that are used to treat specific health conditions and/or cost more than $5,000 per person, per calendar year will require pre-approval ("Prior Authorization"). This means that if your physician prescribes such a specialty drug for you or your covered dependent, you and your physician must submit evidence that supports the need for the drug in order to obtain coverage for it under the Health Care Plan. Should a plan member choose not to submit a request or if the request does not meet the criteria, the claim will be rejected.

To determine if a prescription drug requires prior authorization, please contact our third-party provider, Cubic Health Inc., through the FACET Program for Prior Authorization. Users of this service are encouraged to read and will be subject to Cubic Health Inc's privacy policy. Your personal information and/or personal health information will be collected directly by the third party vendor. NAV CANADA will not receive employee personal information and/or personal health information from FACET, with the exception where an employee expressly consents to specific personal information and/or personal health information being provided to NAV CANADA.

ELIGIBLE EXPENSES

To determine if a specific drug may be eligible for coverage:

1. Go online to www.mysunlife.ca/navcanada.
2. Sign in with your Access ID and password.
3. Click on My coverage.
4. Click on Drug Coverage under the Medical section.

You can get an Access ID and password by calling Sun Life at 1-800-361-6212 or by clicking "Register now" on the sign-in page www.mysunlife.ca/navcanada.

Drugs or supplies must be prescribed by a Doctor or Dentist (or other qualified professionals if applicable provincial legislation permits them to prescribe these drugs) and dispensed by a licensed pharmacist or a Doctor.

Read what limitations and exclusions apply to this coverage:

Eligible Expense	Limitations
Aerochambers with masks for the delivery of asthma medication	For children under six years of age only.
Brand Name Prescription Drugs	Reimbursed at 90% if a generic equivalent does not exist, except if physician completes and submits a Drug Exception form for consideration and approval. If approved by Sun Life reimbursement will be at 95% of brand name cost.
Compounded Prescriptions	Regardless of active ingredients.
Supplies for Diabetes Treatment	• Hypodermic needles, syringes, and chemical diagnostic aids for treatment of diabetes. • Including needles and syringes no earlier than 36 months after purchase of an insulin jet-injector.
Drug-delivery devices to deliver asthma medication	Must be integral to the product.
Erectile Dysfunction Drugs	Maximum reimbursable expense of $1,300[1] for each covered person in any one calendar year.

Eligible Expense	Limitations
Injectable Drugs	Including allergy serums administered by injection.
Life-Sustaining Drugs	Life-sustaining drugs that may not legally require a prescription, 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 • topical ensymatic debriding agents
Prescription Drugs	Identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription.
Replacement Therapeutic Nutrients	Replacement therapeutic nutrients prescribed by an accredited medical specialist for the treatment of an injury or disease (excluding allergies or aesthetic ailments), provided that no other nutritional alternative exists to support the life of the patient.
Smoking Cessation Aids	• Require a prescription • Must not be available over the counter • Lifetime maximum reimbursable expense for each covered person of $1,000[1]
Specialty Drugs	The Prior Authorization Program for Specialty drugs applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. In order for specialty drugs to be covered, both you and your doctor need to provide medical information. You will be covered for these drugs if the information provided meets the medical criteria. If not, your claim will be declined. Please contact our third-party provider, Cubic Health Inc., through the FACET Program for Prior Authorization. Users of

	this service are encouraged to read and will be subject to Cubic Health Inc's privacy policy.
Vitamins and Minerals	• Must not be available over the counter; and • are prescribed for the treatment of a chronic disease, when the customary practice of medicine considers that these products have proven therapeutic value and when no other alternatives are available to the patient.
Weight Loss Drugs	• Require a Prescription. • Covered if person is considered obese as defined by the World Health Organization (including prescribed injectable vitamins/dietary supplements if used in conjunction with a weight loss drug program).

[1]All expenses with a maximum reimbursable amount will be paid at 100% coinsurance.

MAKING A CLAIM

Claiming under the NAV CANADA Plan

Using the Pay Direct Drug Card

If you are a full-time or part-time employee covered under the Health Care Plan, you have access to the Pay Direct drug card feature. This card can be used for prescription drug expenses for you and your registered dependents.

If you do not use your Pay Direct drug card, your pharmacist may charge you more than the customary mark-up rate, and these higher charges are NOT covered by the Health Care Plan.

If you and your spouse are both NAV CANADA employees and you are covered as a dependent under family coverage on your spouse's Health Care Plan, you will not have access to your own Pay Direct drug card as a dependent under your spouse's plan.

Buying Online

If you buy prescription drugs through our mail-order Preferred Pharmacy, you will not need to claim with Sun Life, since they will invoice Sun Life directly for the applicable eligible expenses paid by the Plan.

Paper Claim Form

1. Pay the expense and get a receipt,
2. Complete an Extended Health Care and Health Spending Account Claim Form, and
3. Mail the claim form and original receipt to Sun Life.

Coordination of Benefits with the Pay Direct Drug Card

If your pharmacist is aware that there is a secondary plan and he/she is prepared to accommodate you, they will be able to transmit a claim under the secondary plan, indicating

what amount was allowed under the primary plan. This may permit 100% reimbursement of the cost of the prescription.

However, in this case both you and your spouse must have coverage with Sun Life (and both must have a drug card) or your spouse must have a drug card with a carrier who uses Telus Health Solutions as their pay-direct provider.

If your spouse's health care coverage is not with Sun Life and/or does not have pay-direct with Telus Health Solutions, you will not be able to use your pay-direct drug card for those expenses and must submit a paper claim form for the coordination of benefits portion.

For more information, visit the "Making a Claim" section.

FREQUENTY ASKED QUESTIONS

Brand Name & Generic Drugs

Does the plan cover brand-named drugs?

Yes, but with the following exceptions:

- if no generic drug is approved on the market (coinsurance will be 90%),
- your physician completes a medical exception form for consideration if a brand name drug is medically necessary; the exception request will be reviewed by Sun Life and a decision will be communicated in writing (coinsurance will be 95%).

Otherwise, only 95% of the equivalent least expensive generic drug will be reimbursed.

What are generic drugs?

A generic drug is a copy of a brand name product. Generic drugs contain the same medicinal ingredients as the brand name drug and are considered bioequivalent to the brand name drug product. There may be many generic versions of the same brand name drug.

Nearly 45% of all prescriptions filled by pharmacies use generic drugs, and some hospitals use generic drugs almost exclusively. Chances are that you have received a generic drug at some time, whether you realize it or not.

Are generic drugs safe?

Generic drugs are safe. Like brand-name drugs, they must meet the strict regulations established by Health Canada, and the Food and Drugs Act and Regulations.

Why do generic drugs sometimes look different from brand-name drugs?

Every drug has two types of ingredients: active and non-active. Generic drugs and brand-name drugs share the same active ingredients, which must meet strict government regulations.

However, the non-active ingredients may differ, causing generic drugs to look or taste different from brand-name drugs. Be assured that generic drugs work the same as brand-name drugs, regardless of shape, size, colour and taste.

Can I get a generic version for all my prescription drugs?
Not all drugs have a generic version. Many drugs are protected by patents, which have not expired. Until the patent expires, the company, which owns the patent, is the only company who can produce that drug. Once the patent expires other companies can manufacture the generic version of the drug.

How can I find out if my prescription has a generic version?
Physicians are best at choosing which drug is right for you, but they do not always know which drugs are available in a generic version. Your pharmacist is an excellent source for information on which of your prescriptions can be filled with a generic equivalent.

How do I know if the prescription drug prescribed by my physician is a generic version?
Your physician and/or your pharmacist can confirm if the prescribed drug is a generic version or if a generic equivalent exists in the market. You should tell your physician that your plan will only reimburse the generic equivalent unless they complete an exception request on your behalf.

What is the difference between generic and brand name drugs?
The quality standards for brand name drugs and generic drugs are the same. The ingredients, manufacturing processes and facilities for all drugs must meet the federal guidelines for Good Manufacturing Practices. As well, all drug manufacturers must perform a series of tests, both during and after production, to show that every drug batch made meets the requirements for that product.

The generic drug must contain the same amount of medicinal ingredients as the brand name drug. However, non-medicinal ingredients, such as fillers and ingredients that colour the drug, may be different from those of the brand name product. The generic manufacturer must provide studies showing that the different non-medicinal ingredients have not changed the quality, safety or effectiveness of the generic drug.

To prove that their products are safe and effective, generic drug manufacturers must demonstrate that the generic drug performs similarly to the brand name drug.

Why are brand name drugs so much more expensive than the generic equivalent?
Brand-name drugs require more time and money for initial research. In addition, many also employ vast consumer-marketing campaigns, which also adds to the cost. These costs are incorporated into the total pricing of the drug sold to the consumer. On the other hand, generic drugs require less time and money for research, costing consumers, on average, 30 to 40 percent less.

Drug Card

How do I obtain a drug card?
The first step in obtaining your Access ID and Password required to access your profile and Pay Direct drug card is to register with Sun Life Member Services.

How do I view and print the drug card?
You can visit the Sun Life website at www.mysunlife.ca/navcanada and enter your Access ID and password. Once on the site, you will see a “take me to” drop down menu in the center of the page, where you will select “print drug card”. An image of the drug card will appear on screen. Simply print as many copies as you require.

Will I have any out of pocket expenses when I use the Direct Pay drug card?
When you present your Pay Direct drug card to your pharmacist, you will have to pay the following:

- the per-script fee, if purchase is not at one of the preferred pharmacies ($4 per script fee applies in Quebec, regardless of the pharmacy);
- 5% or 10% coinsurance that applies;
- any drug amount over and above the price of the least expensive generic equivalent unless exception request has been approved by Sun Life;
- eligible drug expenses over the annual maximum;
- any ineligible drug expenses; and/or
- eligible drug expenses for your dependents, subject to the coordination of benefits rules.

How do I use my Pay Direct drug card if I also have coverage under another plan?
If your pharmacist is aware that there is a secondary plan and he/she is prepared to accommodate you, they will be able to transmit a claim under the secondary plan, indicating what amount was allowed under the primary plan. This may permit 100% reimbursement of the cost of the prescription.

However, in this case both you and your spouse must have coverage with Sun Life (and both must have a drug card) or your spouse must have a drug card with a carrier who uses Telus Health Solutions as their Pay Direct provider.

If your spouse’s health care coverage is not with Sun Life and/or does not have Pay Direct with Telus Health Solutions, you will not be able to use your Pay Direct drug card for those expenses and must submit a paper claim form for the coordination of benefits portion.

How do I use the Pay Direct drug card outside Canada?
The Pay Direct drug card can only be used in Canada. If you are outside the country, you must pay for the expenses and submit a paper claim form to Sun Life Financial to obtain reimbursement.

Why won’t the pharmacist accept the Pay Direct drug card for my dependent's drug expenses?
There are a few reasons why the expense would be declined at the pharmacy counter:

- you do not have family coverage under the NAV CANADA Health Care Plan (you must apply for the family coverage and register your dependents before you can claim drug expenses with your Pay Direct drug card);

- your dependent is not registered in the system (e.g. positive enrolment process within your Workday Self-Serve Account); or
- your spouse does not have a Pay Direct drug card feature under his/her Health Care Plan or Telus Health Solutions is not their Pay Direct Provider.

In cases 2 and 3, you must pay for the expense and submit an Extended Health Care and Health Spending Account claim form to Sun Life Financial.

How can I obtain a card with my dependent's information on it?
The Pay Direct drug card is not personalized for every family member covered under your plan. As the employee card holder, your information is primary, and the dependent information is linked to your record.

My name does not appear on the Pay Direct drug card. Can I still present it for use or does the named person need to be present?
If you are a registered dependent of the named person on the card, you can use the Pay Direct drug card without the named person being present. You will need to advise the pharmacist of your relationship to the plan member and your date of birth. The pharmacist will confirm that the information matches what is on file with Telus Health Solutions and process accordingly.

Health Spending Account

How do I claim drug expenses under my Health Spending Account?
You can submit electronically, either online or through the Sun Life mobile app, or by paper form. See the Health Spending Account section for specific instructions.

Expenses incurred in the previous calendar year must be processed using a paper claim form.

Mail Order Form

Can I use a mail-order pharmacy and still get reimbursed?
A mail-order prescription program is available through our mail-order Preferred Pharmacy for all eligible Health Care Plan members living in Canada.

How it works:

- Our mail-order Preferred Pharmacy will bill Sun Life directly for your eligible prescription drug orders.
- The only out-of-pocket expense for you is:
    - 5% or 10% coinsurance that applies;
    - any drug amount over and above the price of the least expensive generic equivalent unless exception request has been approved by Sun Life;
    - eligible drug expenses over the annual maximum; and/or
    - any ineligible drug or items (such as regular drugstore items) you choose to purchase.

You can claim the unpaid portion of expense claims through your Health Spending Account, or to another plan for coordination of benefits.

For further information about the Preferred Pharmacy Network contact the HR Employee Centre (HREC) at HREC-CERH@navcanada.ca or 1-888-774-4732, option 2.

Per Script Fee

How does the per script fee affect me?

If your prescription drug expense is not purchased at one of the Preferred Pharmacies Sun Life Financial calculates the eligible expense you claim by deducting a per script fee for each Drug Identification Number (DIN) indicated on the receipt once the coinsurance has been applied. A $4 per script fee applies in Quebec, regardless of the pharmacy.

Prescription Drugs

I am trying to stop smoking. Can the plan help?

Yes, but only with smoking cessation aids that require a prescription and are not available over the counter, to a lifetime maximum reimbursable expense of $1,000.

Does the plan cover Viagra?

Yes, the plan covers all erectile dysfunction drugs up to a maximum reimbursable expense of $1,300 for each covered person in any one calendar year.

Does the plan cover experimental drugs?

Experimental products or treatments are never eligible unless Sun Life is satisfied that substantial evidence exists, 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.

Certain life-sustaining non-prescription drugs are covered if prescribed by a physician.

Does the plan cover an unlimited supply of therapeutic or maintenance drugs?

Although there is no maximum limit for drugs, you may only claim what can reasonably be used in three months. The plan will only reimburse a maximum 100-day supply at a time.

Does the plan cover supplies for diabetics?

Yes, including hypodermic needles, syringes, and chemical diagnostic aids. But, if you buy an insulin jet-injector, you cannot claim needles and syringes for the next 36 months.

Does the plan cover contraceptives?

Yes, oral and non-oral contraceptives prescribed by a physician and dispensed by a licensed pharmacist.

Are injectable drugs covered?

Yes, including allergy serums administered by injection.

Where can I obtain a list of prescription drugs that require prior authorization?

Please contact our third-party provider, Cubic Health Inc., through the FACET Program for Prior Authorization. Users of this service are encouraged to read and will be subject to Cubic Health Inc's privacy policy.

How can I claim weight loss drugs?

Charges for prescription weight loss drugs (includes injectable vitamins and dietary supplements prescribed by a physician in conjunction with a weight loss drug program) will be considered an eligible expense only if the covered person is deemed obese as defined by the World Health Organization (WHO). To find out more about the Body Mass Index and the WHO, refer to their website.

Preferred Pharmacy Network

WHAT'S COVERED?

NAV CANADA is committed to providing its members with sufficient information to spend benefit plan dollars in the most cost-effective way so a Preferred Pharmacy Network (PPN) has been established to help you save on your prescription drug costs.

Participation is voluntary and enables you to save money while accessing comprehensive pharmacy services with the following benefits:

- Elimination of the $10 per script fee
- Provides value and convenience for plan members

Due to specific provincial regulations, the network is not authorized to include Quebec pharmacies. The per script fee of $4 will continue to apply to all prescription drugs purchased in Quebec.

The per script fee of $10 will continue to apply to all prescription drugs purchased outside the PPN.

HOW IT WORKS

1. Select the Preferred Pharmacy Network pharmacy closest to you or that best meets your needs.
2. Give your new prescription to the pharmacist or transfer an existing prescription.
3. Give your Pay Direct Drug Card information to the pharmacist.
4. Enjoy lower out-of-pocket costs right away.

Select your province from the list below to find the preferred pharmacy available in that province. Click on the provider site to find the closest pharmacy nearest you by using the "Locations" and/or "Stores" link and "Pharmacy" filter feature.

Province/Territory	Pharmacy
Quebec	The Code of Ethics of the Association Québécoise des Pharmaciens Propriétaires (AQPP) includes a number of provisions precluding price rebating (or other profit sharing) to PBMs (insurers, drug card providers) or plan sponsors in exchange for plan member incentive to use a preferred pharmacy.

Province/Territory	Pharmacy
Alberta British Columbia Manitoba Newfoundland & Labrador Nova Scotia Saskatchewan	**In Store** Costco Pharmacy • Membership is not required to purchase prescription drugs • Receive a $10 Costco Cash Card when you sign up for a new Costco Gold Star or Executive Membership. Walmart Pharmacy • 10% discount on prescription glasses, lenses and contact lenses when purchased at a Walmart Vision Centre. The discount offered does not apply to vision exams. **Mail Order** MediTrust Pharmacy • Rexall discount card once you complete a survey after you have signed up for the MediTrust home delivery service through the MediTrust website.
New Brunswick Ontario	**In Store & Mail Order** Costco Pharmacy • Membership is not required to purchase prescription drugs • Receive a $10 Costco Cash Card when you sign up for a new Costco Gold Star or Executive Membership. Walmart Pharmacy • 10% discount on prescription glasses, lenses and contact lenses when purchased at a Walmart Vision Centre. The discount offered does not apply to vision exams. **Mail Order** MediTrust Pharmacy • Rexall discount card once you complete a survey after you have signed up for the MediTrust home delivery service through the MediTrust website.
Northwest Territories Prince Edward Island Yukon	**In Store** Walmart Pharmacy • 10% discount on prescription glasses, lenses and contact lenses when purchased at a Walmart Vision Centre. The discount offered does not apply to vision exams. **Mail Order** MediTrust Pharmacy • Rexall discount card once you complete a survey after you have signed up for the MediTrust home delivery service through the MediTrust website.
Nunavut	**Mail Order** MediTrust Pharmacy • Rexall discount card once you complete a survey after you have signed up for the MediTrust home delivery service through the MediTrust website.

FREQUENTLY ASKED QUESTIONS

Do I have to use a pharmacy in the PPN?

No. Using a pharmacy in the Preferred Pharmacy Network is optional but it offers many benefits including lower out-of-pocket expenses. More importantly, the plan will charge you the per script fee of $10 if your prescription drug expense is not purchased at one of the Preferred Pharmacies. The $4 per script fee applies in Quebec, regardless of the pharmacy.

How do I find a participating pharmacy?

Go to the “How it Works” section and select your province from the list. Participating pharmacies and their websites are shown for each province.

Why is there no PPN in Quebec?

The Code of Ethics of the Association Québécoise des Pharmaciens Propriétaires (AQPP) includes a number of provisions precluding price rebating (or other profit sharing) to PBMs (insurers, drug card providers) or plan sponsors in exchange for plan member incentive to use a preferred pharmacy.

Do I have to provide my pay-direct drug card information to the preferred pharmacy to access the preferred rates and waiver of script fee?

Yes. In order to access the waiver of per script fee and the lower cost preferred rates you must provide your drug card information to the pharmacist at the point of sale. If the drug card information is not presented, you will not benefit from the lower cost preferred arrangement.

Travel

WHAT'S COVERED?

In an out-of-province emergency, call Allianz Global Assistance.

In Canada and the US: 1-800-854-7589

From elsewhere, call collect: 1-519-742-6768

Personal Travel

100%

Reasonable and customary charges for emergency health care:

- outside your province of residence, and
- above what is payable by your provincial health plan, to a maximum reimbursable expense of $1,000,000 for each covered person for any one period of travel.

The expense must be:

- prescribed by a physician and medically necessary,
- incurred no more than 60 days from the date you leave home or any time you are on official travel status (if treatment continues beyond 60 days, related expenses will be covered),
- incurred because of an emergency, and
- payable in part by the provincial plan.

Business Travel

100%

Reasonable and customary charges for emergency health care:

- outside your province of residence,
- above what is payable by your provincial health plan, to a lifetime maximum reimbursable expense of $500,000 for each employee (emergency health benefits are not paid on behalf of your spouse or children), and
- supplies and services required within 60 days of the emergency for emergency medical treatment.

All active employees under age 75 who live in Canada and are travelling for business. Spouse under age 75 and children of covered employees, during relocation or related house-hunting trip:

Management Employees	4 x adjusted insurable earnings (to a maximum of $500,000)
Spouse	$100,000
Children	$10,000

ELIGIBLE EXPENSES

Personal Travel

Eligible expenses include:

- public-ward accommodation and auxiliary hospital services in a general hospital,
- the services of a physician,
- out-patient services in a hospital,
- one-way economy airfare for the patient and professional attendant, back to the province of residence, when medically necessary,
- medical evacuation by ambulance, when Sun Life determines that suitable care is not available where the emergency occurs,
- family assistance, for example, reimbursement of expenses to return dependent children, under age 16, to Canada, subject to certain limits (combined maximum payable - $2,500 for any one travel emergency),
- 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 (messages held up to 15 days for family and business associates),
- advance hospital and medical expense payment, and
- return of the deceased in the event of death, to a maximum of $3,000.

If a treatment or service is not offered in the patient's province of residence and the person is referred to a hospital in another province, in writing, by the attending physician in his/her province of residence, the plan pays 100% for reasonable and customary charges for the same services, up to a maximum of $25,000 per illness.

Business Travel

Eligible expenses include:

- drugs and medicines available only by prescription and listed in the current Compendium of Pharmaceuticals and Specialties,
- private-duty nursing, prescribed by a physician as medically necessary, where the service is provided by a registered nurse not a member of your family or ordinarily resident in your home, to a maximum of $1,000 per person,
- transportation by local licensed ambulance,
- diagnostic laboratory and X-ray examinations,
- administration of anesthesia, oxygen, blood, and blood transfusions,
- semi-private hospital room and board charges and related services and supplies, including drugs administered while confined to hospital for up to 30 days, and
- physician charges for medical or surgical services.

The plan also covers reasonable and customary charges for transportation, medical services, and medical supplies for an emergency evacuation, to a maximum of $50,000 for each employee, as long as:

- the attending physician certifies that:
    - your medical condition warrants immediate transportation to the nearest hospital where appropriate medical treatment can be obtained, or
    - after being treated at a local hospital, your medical condition warrants transportation to your Canadian residence for further medical treatment or to recover, or both,
- travel is by the most direct and economical route, and
- expenses for special transportation (that is, any land, water, or air conveyance required to transport you during an emergency evacuation, including, but not limited to, air ambulance, land ambulance, and private motor vehicle) are those required by the regulations of the conveyance in which you are transported.

If you, your spouse, or child sustain a covered injury and are confined to a hospital more than 150 kilometers from home, the plan pays reasonable and customary charges to bring a member of your immediate family (that is, your legal or common-law spouse, parents, grandparents, children over age 18, brother, or sister) by the most direct route by licensed common carrier to be with the person. The attending physician must recommend this visit in writing. The maximum payable is $10,000.

MAKING A CLAIM

Allianz Global Assistance Canada will co-ordinate payments from the provincial health care plan and Sun Life for members enrolled in supplementary coverage. You do not need to submit a claim, unless you want to claim for co-ordination of benefits under another plan.

If you do not contact Allianz Global Assistance Canada:

1. Get detailed receipts,
2. Submit expenses to your provincial health plan within 14 days of your return to Canada,
3. Once the province reimburses you, send Sun Life:
    - an Extended Health Care and Health Spending Account Claim Form,
    - duplicate receipts (or photocopies), and
    - the provincial statement of payment.

Send in your claim as quickly as possible, because provincial plans have very strict time limits. If claims are late, they may not be paid by the province or Sun Life.

For all expenses outside Canada under Business Travel Accidental Death and Dismemberment Insurance, call the HR Employee Centre (HREC) at 1-888-774-4732 option 2, after contacting Allianz Global Assistance at the number above.

TRAVEL TIPS

- For detailed travel health information, visit www.travelhealth.gc.ca, a Health Canada site that provides:
  - current information on international disease outbreaks,
  - immunization recommendations for international travel,
  - general health advice for international travelers, and
  - disease-specific treatment and prevention guidelines.
- If you plan to travel off the beaten track, you may need to take extra health precautions. Seek medical advice at least six weeks before you travel, since some vaccinations should not be given together.
- Review NAV CANADA's travel coverage and decide whether you need to buy additional insurance.
- Carry your benefit card as proof of insurance coverage.
- Know how to contact Allianz Global Assistance Canada for emergency health claims, and make sure that your traveling companion(s), travel agent and someone at home know how to do so as well.
- Make sure you know about health risks specific to your destination. Take first aid supplies along.
- Keep prescription medication in its original container and carry a doctor's prescription for any controlled drug.
- Do not leave prescription medication in your checked luggage, in case your baggage goes astray.
- Carry a medical certificate for syringes if you require them for medical purposes.
- Ensure that you have all required visas. Make photocopies of your visas and keep them separate from the originals.
- Photocopy the identification page in your passport. Keep a copy separate from the passport and leave another copy with someone at home.
- For travel reports on various countries throughout the world, visit Consular Affairs and consult the travel report for your destination.
- Travel to Cuba: upon entry into Cuba you will be required to present proof of travel insurance.
- There are a number of hospitals that have been identified in California, Florida, Arizona and Nevada that are now requiring a deposit from Canadian patients regardless of whether or not they are billing the patient or the insurance company directly. Where possible, contact Allianz Global Assistance Canada before incurring any expenses.

Health Practitioner

WHAT'S COVERED?

90%

The Health Care Plan covers reasonable and customary charges incurred for eligible expenses, as long as they:

- are medically necessary for the treatment of disease or injury
- are within the practitioner's area of expertise,
- require the skills and qualifications of such a practitioner, and
- are provided by a practitioner licensed, registered, or certified through the respective provincial licensing body or professional organization.

You pay the remaining cost.

Expenses with a maximum reimbursable amount will be paid at 100%.

ELIGIBLE EXPENSES

Type of Expense	Maximum Reimbursable Expense
Acupuncturist	$300[1] for each covered person in any one calendar year
Chiropodist/Podiatrist	
Naturopath	
Osteopath	
Registered Massage Therapist	
Chiropractor	$500[1] for each covered person in any one calendar year
Electrology	• By an electrologist or a physician. • Limited to treatment to remove excessive hair from exposed areas of the face and neck (when the patient suffers from severe emotional trauma as a result of the condition) • $20[1] for each visit • psychiatrist's or psychologist's prescription required every 12 months
Physiotherapist	• Unlimited • Physician's prescription required every 12 months
Psychologist	• $1,000[1] for each covered person in any one calendar year
Speech-Language Pathologist	• $500[1] for each covered person in any one calendar year • Physician's prescription required every 12 months

[1]All expenses with a maximum reimbursable amount will be paid at 100% coinsurance

FREQUENTLY ASKED QUESTIONS

Does the plan cover the cost of any laboratory tests or X-rays?

Yes, that is:

- tests done in a commercial laboratory for diagnosis of an illness (not including tests in a physician's office or pharmacy), and
- X-rays ordered by a physician, chiropractor, osteopath or chiropodist/podiatrist.

The plan does not cover the cost of laboratory tests or X-rays done in a private laboratory.

Dentist

WHAT'S COVERED?

Reimbursement

The Dental Care Plan reimburses:

- 90% of the cost of basic services
- 50% of the cost of major services

Payment will not be made for any portion of a treatment that is more expensive than the usual, reasonable and customary charge for the least expensive alternate service or material, consistent with adequate dental services, when such alternative service or material is customarily provided.

Maximums

The following maximums are applied to the amount of expense for each covered person:

- $1,750 per calendar year for basic and major services combined, other than orthodontics, and
- $2,500 lifetime maximum for orthodontics.

You pay the remaining cost.

If you join the plan on or after July 1 in a calendar year, the maximum benefit payable in that year is $875 for services other than orthodontics.

ELIGIBLE EXPENSES

Eligible expenses are charges for the procedures listed below up to the amount in the Suggested Dental Fee Guide, as approved by the relevant Dental Association, for these procedures.

When determining what will be paid for the procedure, Sun Life will first find out if alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure the dentist performed. Sun Life will not pay more than the reasonable and customary cost of the least expensive alternate procedure.

If treatment is likely to cost more than $300, Sun Life recommends that you have your dentist submit a treatment plan and expected cost to Sun Life. In return, Sun Life will let you know how much of the cost the plan will pay.

Read what exclusions apply to this coverage.

Regular Dental Expenses

Type of Expense	Reimbursement
Anesthesia in connection with oral surgery	90%
Bridges/dentures • exams, films and diagnostic casts • addition of tooth to a removable denture • partial and complete dentures • pontics (fixed bridges) • retainers • abutments (fixed bridges) • retentive pins in abutments • repairs of fixed appliances • other prosthodontic services	50%
Consultations with another dentist	90%
Crowns, inlays/onlays, and other restorative services • gold foil & inlays • retentive pins, posts and cores • porcelain inlays • crowns • other restorative services	50%
Denture repairs (minor) • repairs • adjustments • relining and rebasing (once every 3 years)	90%
Emergency services not otherwise specified	90%
Endodontics (root canals) • pulp capping • pulpotomy • root canal therapy • periapical services • other endodontic procedures	90%
Examination and diagnosis • complete oral examination • recall oral examination (once every 9 months) • specific oral examination • emergency oral examination • treatment planning	90%
Fillings	90%

Type of Expense	Reimbursement
• amalgam • silicate • acrylic or composite • pin reinforcements for these restorations	
House calls, hospital calls and special office visits	90%
Oral surgery • uncomplicated removal of tooth • surgical removal and tooth repositioning • alveoplasty, gingivoplasty, stomatoplasty, osteoplasty, tuberoplasty • removal of excess mucosa • surgical excision or incision • removal of cyst • removal of impacted teeth • repair of soft tissue • frenectomy, dislocations • miscellaneous surgical services	90%
Orthodontics • orthodontic exam • films • orthodontic diagnostic casts • surgical services • observation and adjustments • repairs, alterations • removable appliances • fixed appliances • retention appliances • appliances to control harmful habits	50%
Periodontics (treatment of gum disease) • non-surgical, surgical and post-surgical treatment • occlusal equilibration (not exceeding 8-time units every 12 months) • scaling and root planing • other periodontic services	90%
Preventive services • dental cleaning and polishing (once every 9 months)	90%

Type of Expense	Reimbursement
• topical application of fluoride (once every 9 months) • pit and fissure sealants (for children under age 15 only) • caries control • enameloplasty • space maintainers (not involving movement of teeth) • oral hygiene instructions (1 per benefit year)	
Tests, lab work • biopsy of oral tissue • pulp-vitality tests	90%
X-rays • periapical (one complete series every 36 months) • occlusal • bitewings (once every 9 months) • extra-oral • sialography, uses of dyes • panoramic (once every 3 years) • interpretation of radiographs from another source • tomography	90%

Dental Injury

Claims for dental injury are claimed through the Health Care Plan first, and any balance, from the Dental Care Plan.

The Health Care Plan covers 90% of reasonable and customary charges for management employees for the services of a dentist/dental surgeon (as well as charges for braces and splints) required to treat a fractured jaw or accidental injuries to natural teeth caused by an external, violent injury or blow. Accidents associated with cleaning, chewing, and eating are not covered.

The Dental Care Plan covers up to 90% of any remaining balance for active management employees.

Treatment must take place no more than 12 months after the accident (for children under the age of 17 treatment must take place before the child reaches age 18).

Dental Surgery

You claim from the Dental Care Plan first, and any balance, from the Health Care Plan.

The Dental Care Plan covers up to 90%.

For any remaining balance, the Health Care Plan covers 90% of reasonable and customary charges for management employees for the following oral surgical procedures:

- Avulsion of nerve - supra or infra-orbital
- 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
- Frenectomy - labial or buccal (lip or cheek)
- Fractures and dislocations
  - dislocation—temporomandibular joint (or jaw)
    - closed or open reduction
  - fractures—mandible
    - no reduction, closed reduction, or open reduction
  - fractures—maxillar or malar
    - no reduction, closed reduction, open reduction, or complicated open reduction
- 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
- Lingual (tongue)
- Removal of teeth or roots
  - removal of impacted teeth
  - removal of root or foreign body from maxillar antrum
  - root resection—apiectomy or apicoectomy
    - anterior teeth
    - bicuspids
    - molars
- Repair of antro-oral fistula
- Sialolithotomy - simple
- Sialolithotomy - complicated
- Sulcus deepening, ridge reconstruction
- Torus (bone biopsy)
- Treatment of traumatic injuries
  - repair of soft tissue lacerations
  - debridement, repair, suturing

MAKING A CLAIM

Regular Dental Expenses & Dental Surgery

If Your Dentist Submits Electronically

Make sure all your personal information is correct, including plan number 25298 and your member ID number.

If Your Dentist Does Not Submit Electronically

You must submit your claim directly to Sun Life either electronically or by paper claim form.

E-claims submission is not available for all types of dental claims. Send Sun Life a paper claim form for any of the following types of dental claims:

- requests for predeterminations/estimates of coverage on proposed dental work;
- claims for bridges, crowns or dentures;
- claims where the dentist gave you x-rays, tooth molds or supporting documentation/correspondence (these need to be submitted with your paper claim);
- claims where payment is assigned to your dentist (if permitted under your plan);
- claims as a result of an accident;
- out of Canada claims; and
- orthodontic claims: if Sun Life Financial has approved your treatment plan, you can submit your claims online. If your treatment plan has not been submitted to Sun Life, please include it with your claim form and your receipts.

Accidental Injury

These claims cannot be submitted electronically by your dentist, they must be submitted by paper claim form.

1. Have your dentist complete the appropriate sections of the Dental and Health Spending Account Claim Form,
2. Make sure that the claim is not sent electronically to the Dental Care Plan,
3. Attach the Dental claim form to an Extended Health Care and Health Spending Account Claim Form, and
4. Send both to Sun Life.

FREQUENTLY ASKED QUESTIONS

How is the amount of the maximum eligible expense determined?

If you...	The maximum eligible expense is calculated using...
Live and go to the dentist in Canada	The current dental fee guide in the province or territory where the dentist is located
Live in Canada but go to the dentist outside of Canada	Reasonable and customary charges (the amount that would have been charged in your province of residence determines the annual maximum)

Do I need to get pre-approval for expensive dental treatment?

If treatment is likely to cost more than $300, Sun Life recommends that you have your dentist submit a treatment plan and expected cost to Sun Life. In return, Sun Life will let you know how much of the cost the plan will pay.

What if I need dental surgery or dental treatment after an accident?

- **Dental Injury**
  Treatment must take place no more than 12 months after the accident (for children under age 17 treatment must take place before the child reaches age 18).

  You claim from the Health Care Plan first, and any balance, from the Dental Care Plan.

  The Health Care Plan covers up to 90%.

  For any remaining balance, the Dental Care Plan covers 90% of reasonable and customary charges for certain oral surgical procedures.

- **Dental Surgery**
  You claim from the Dental Care Plan first, and any balance, from the Health Care Plan.

  The Dental Care Plan covers up to 90%.

  For any remaining balance, the Health Care Plan covers 80% of reasonable and customary charges for certain oral surgical procedures.

EXCLUSIONS

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

- Services or supplies payable or available (regardless of any waiting list) under any government sponsored plan or program unless explicitly listed as covered under the benefit or any portion thereof, that are the legal liability of any other party.
- Any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.
- Charges for appointments not kept or completion of claim forms.
- Expenses related to services or supplies of the type normally intended for sport or home use, such as but not limited to, mouth guards.
- Charges for dental services due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.
- The portion of the charge which is the legal liability of another party.
- Any services or supply for which there would be no charge in the absence of this coverage.
- 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.
- Services rendered and supplies purchase prior to the date the person became covered under this
  Plan.
- 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.
- 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 temporo-mandibular joint dysfunction (TMJ dysfunction) or vertical dimension correction.

- Related to implants, other than the reasonable and customary cost of the least expensive alternate procedure as determined by Sun Life,
- 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.

Limitations for Prosthodontic Appliances

Charges for a replacement bridge or replacement standard denture, are not considered an eligible expense, unless:

- it is needed as a result of the removal of additional natural teeth after insertion of the existing bridge or standard denture,
- the existing bridge or standard denture is at least 5 years old and cannot be made serviceable,
- the existing bridge or denture was temporarily inserted, provided that the replacement bridge or denture is inserted within 12 months of the temporary bridge or denture and the replacement will thereafter be deemed permanent for the purposes of this provision,
- the replacement bridge or denture is required as the result of the insertion of an initial opposing denture after the date the person becomes covered under this Plan, or
- the replacement bridge or denture is required as the result of accidental dental injury to a natural tooth that occurred after the date the person becomes covered under this Plan.

Health Spending Account

WHAT'S COVERED?

$750

If you are a full-time or part-time employee covered under the Health Care Plan, you are entitled to $750 (one allocation per certificate number) each calendar year in a Health Spending Account.

The Health Spending Account:

- can be used to claim eligible expenses for yourself and your eligible dependents
- not transferable to cash
- pro-rated based on start date of Health Care Coverage

If you are a Quebec resident, covered under the Health Care Plan, and you claim health or dental expenses under your Health Spending Account, the amount you claim each calendar year is subject to provincial income tax. It is your responsibility to report the amount claimed when you file your income tax. If you live in Quebec and work in another province you will not receive a Relevé 1 slip. These amounts will be reported in a separate letter, which will be distributed at the same time as the T4 slips. If you live and work in Quebec, these benefits will be reported in Box A and Box J of the Relevé 1 slip.

ELIGIBLE EXPENSES

Any expenses that are tax-deductible and listed in the Income Tax Act, its regulations and Interpretation Bulletins, for yourself, and your eligible dependents.

For more information on what is covered you can access the Health Spending Account link on your plan member profile homepage by logging in at www.mysunlife.ca/navcanada or contact a Sun Life Customer Service Representative at Sun Life, at 1-800-361-6212.

MAKING A CLAIM

Claiming Under the NAV CANADA Plan

To receive maximum benefits, begin by claiming the expense(s) under the Health Care Plan or Dental Care Plan. If you have an unpaid amount or any expenses that are not covered under the above plans you can submit either electronically or by paper claim form:

*Expenses incurred in the previous calendar year must be submitted by paper claim form.

Mobile

1. Go to Sun Life Mobile.
2. Sign in with your Access ID and password.
3. Click on Submit a Claim.
4. Select Health Spending Account.

Online

1. Go to www.mysunlife.ca/navcanada.
2. Sign in with your Access ID and password.
3. Click on My claims.
4. Select Health Spending Account e-claim under the Submit a claim section.

You can get an Access ID and password by calling Sun Life at 1-800-361-6212 or by clicking "Register now" on the sign-in page www.mysunlife.ca/navcanada.

Paper Claim Form

1. Pay the expense and get a receipt.
2. Complete all applicable sections of the claim form including:
    - health expenses: Part 3 of the Extended Health Care and Health Spending Account Claim Form
    - dental expenses: Part 5 of the Dental and Health Spending Account Claim Form,
3. Mail both the claim form and original receipt to Sun Life.

Coordination of Benefits

To maximize your coverage using the Health Spending Account, if you and your spouse are covered by more than one Benefit Plan, expenses should be submitted as follows:

1. To the plan that covers you as a full-time or part-time employee,
2. To the secondary plan, and
3. Any remaining balance to your Health Spending Account.

EXCLUSIONS

Any expense incurred by the employee or a covered dependent, which would not qualify as the employee's medical expenses in accordance the Income Tax Act of Canada as amended from time to time, excluding any such expense, or portion of such expense, payable under any other private or governmental plan.

Any expense that was not incurred in the calendar year for which the Health Spending Account entitlement is in effect. You have 90 days after the end of the calendar year to submit your claims.

Vision

WHAT'S COVERED?

90%

The Health Care Plan pays reasonable and customary charges incurred for eligible expenses.

You pay the remaining cost.

Expenses with a maximum reimbursable amount will be paid at 100%.

ELIGIBLE EXPENSES

Read what limitations and exclusions apply to this coverage.

Type of Expense	Limitation
Artificial Eyes and Replacements	Including replacement of existing eye, no earlier than: • 60 months after the last purchase, for covered persons over age 21, or • 12 months after the last purchase, for spouse or children 21 years of age or less
Eye Examinations	By a licensed optometrist. One examination for each covered person in each two-year calendar period
Eyeglasses and Contact Lenses needed to correct vision, prescribed by an ophthalmologist or optometrist, and repairs	Maximum reimbursable expense of $225[1] for each two-year calendar period
Eyeglasses or Contact Lenses (initial purchase) required as the direct result of surgery or an accident	Must be purchased within six months of such surgery or accident, or as soon as is reasonably possible, in Sun Life's opinion
Laser Eye Surgery	Can be claimed against the same maximum reimbursable expense of $225[1] as eyeglasses and contact lenses in subsequent two-year calendar period (under the regular Health Care Plan, not the Health Spending Account) until the full cost has been claimed.

[1] All expenses with a maximum reimbursable amount will be paid at 100% coinsurance.

MAKING A CLAIM

Eyeglasses, contact lenses and eye exams

You can submit your claim electronically or by paper claim form.

Mobile

1. Go to Sun Life Mobile.
2. Sign in with your Access ID and password.
3. Click on Submit a Claim.
4. Select Vision.

Online

1. Go to www.mysunlife.ca/navcanada.
2. Sign in with your Access ID and password.
3. Click on My claims.
4. Select Vision e-claim under the Submit a claim section.

You can get an Access ID and password by calling Sun Life at 1-800-361-6212 or by clicking "Register now" on the sign-in page www.mysunlife.ca/navcanada.

Paper Claim Form

1. Pay the expense and get a receipt.
2. Complete an Extended Health Care and Health Spending Account Claim Form.
3. Mail the claim form and original receipt to Sun Life.

Laser Eye Surgery, Artificial Eyes, and Replacements

You must submit your expense by paper claim form.

1. Pay the expense and get a receipt.
2. Complete an Extended Health Care and Health Spending Account Claim Form.
3. Mail both the claim form and original receipt to Sun Life.

You can continue to resubmit the laser surgery expense claim under the regular Health Care Plan until the balance is paid, as long as the person for whom you are claiming remains continuously covered under the plan. You cannot continue to resubmit the laser surgery expense claim under the Health Spending Account.

Once the next two-year claiming period begins, submit a new Extended Health Care and Health Spending Account Claim Form with a copy of your original receipt and explanation of benefits form received from Sun Life.

FREQUENTLY ASKED QUESTIONS

Does the plan cover sunglasses?
Yes, as long as they have prescription lenses.

How does the two-year claiming period work?
If you received a reimbursement of $225 on the purchase of eyeglasses, contact lenses or laser eye surgery during the two-year period that runs from January 1, 2015 to December 31, 2016, you cannot claim again until the new two-year period (January 1, 2017 to December 31, 2018) begins.

For laser eye surgery claims, you may re-submit the expense, as long as the person is covered by the plan, in every two-year calendar period until the full cost of the surgery has been claimed. You cannot re-submit the expense under the Health Spending Account for that new calendar year period.

Hospital & Ambulance

WHAT'S COVERED?

Hospital

100%

Reasonable and customary costs for semi-private hospital accommodation.

If you choose a private hospital room, you must pay the difference in cost between semi-private and private accommodation. The plan will only pay the hospital for the semi-private accommodation costs.

Read what limitations and exclusions apply to this coverage.

Ambulance

90%

Reasonable and customary charges for ground or air ambulance services, as long as:

- the service is prescribed by a physician and medically necessary, and
- the provider is licensed.

You pay the remaining cost.

Read what limitations and exclusions apply to this coverage.

MAKING A CLAIM

Hospital

If you, your spouse, or any of your children are hospitalized, give the admitting clerk your benefit card.

Generally, hospitals bill the plan directly. If your hospital does not, send a completed Extended Health Care and Health Spending Account claim form with the hospital's invoice to Sun Life. They will either pay the hospital directly, if the claim was sent directly from the hospital, or reimburse you, up to the value of semi-private accommodation.

Ambulance

Expense claims must be submitted by paper form.

1. Pay the expense and get a receipt.
2. Complete an Extended Health Care and Health Spending Account claim form.
3. Mail the claim and original receipt to Sun Life.

FREQUENTLY ASKED QUESTIONS

What if I just want ward accommodation?
Your provincial health plan covers 100% of the cost.

Can I get higher reimbursement from the plan?
No, there is no option to pay more for higher coverage. If you choose a private room when you are hospitalized, you must pay the difference in cost between semi-private and private accommodation.

Does the plan cover other types of hospital services?
Generally, in Canada, hospital charges are covered by your provincial plan.

Can I get the ambulance to take me to any hospital I want?
No, it must take you to the nearest hospital equipped to provide the required treatment.

Does the plan cover the cost of a medical certified attendant to accompany me?
Yes, if medically necessary.

Hearing Aids

WHAT'S COVERED?

Regular Hearing Aids

Of reasonable and customary charges for hearing aids prescribed by an ear, nose, and throat specialist, including repairs but excluding batteries. Maximum reimbursable expense of $1,000 for each covered person every 60 months.

100%

To be eligible:

- any provincial plan must have paid its maximum for the service or product, and
- the service or product must be prescribed by a physician and medically necessary.

You pay the remaining cost.

Read what exclusions apply to this coverage.

As the result of surgery or an accident

Of the initial purchase of hearing aids required as the direct result of surgery or an accident. Must be purchased within six months of the surgery or accident, or as soon as is reasonably possible, in Sun Life's opinion. No maximum reimbursable expense.

90%

To be eligible:

- any provincial plan must have paid its maximum for the service or product, and
- the service or product must be prescribed by a physician and medically necessary.

You pay the remaining cost.

Read what exclusions apply to this coverage.

Medical Supplies & Services

WHAT'S COVERED?

90%

The Health Care Plan pays reasonable and customary charges for covered services or products, as long as:

- any provincial plan has paid its maximum for the service or product, and
- the service or product is prescribed by a physician and medically necessary.

You pay the remaining cost.

Expenses with a maximum reimbursable amount will be paid at 100%.

ELIGIBLE EXPENSES

Read what limitations and exclusions apply to this coverage:

Eligible Expenses	Limitations
Artificial Limbs, temporary and permanent (to replace temporary)	Including replacement of existing prosthesis, no earlier than: • 60 months after the last purchase for patients over age 21, or • 12 months after the last purchase for spouse, or child age 21 or less. Earlier replacement may be approved if medically proven that growth or shrinkage of surrounding tissue requires replacement at an earlier date.
Bandages and Surgical Dressings	Required for the treatment of an open wound or ulcer.
Blood-glucose Monitors	Blood-glucose monitors for insulin-dependent diabetics and for legally blind or colour blind non-insulin-dependent diabetics. Including repair or replacement, no earlier than 60 months following the date of purchase of the monitor.
Braces that contain either metal or hard plastic	Not including dental braces or braces used primarily for athletic use.
Breast Prosthesis following mastectomy	One replacement for each prosthesis in any 24-month period.

Eligible Expenses	Limitations
Colostomy, ileostomy and tracheostomy supplies, catheters and drainage bags for incontinent, paraplegic or quadriplegic patients	N/A
Durable equipment manufactured specifically for medical use, required for temporary and therapeutic use in the patient's private residence - rental, or purchase at Sun Life's option - including walkers, hospital beds, apnea monitors and alarm systems for enuretic patients	Reimbursement limited to the cost of non-motorized equipment, unless medically proven that motorized is required.
Elasticized support stockings and elasticized apparel for burn victims	Manufactured to individual patient specifications, or with a minimum compression of 30 millimeters.
Insulin jet-injector device for insulin-dependent diabetics	Maximum reimbursable expense of $760[1] for each covered person every 36 months.
Insulin pumps and associated equipment for insulin-dependent diabetics, including repair or replacement at least 60 months following the date of purchase	Reimbursed only if prescribed by a physician associated with a recognized center for the treatment of diabetes at university teaching center.
Orthopedic brassieres	Maximum reimbursable expense of $100[1] for each covered person in any one calendar year.
Orthopedic shoes that are an integral part of a brace or are specifically constructed for the patient, including modifications to such shoes, prescribed by a physician, chiropodist or podiatrist	Maximum reimbursable expense for each covered person in any one calendar year of: • total charges, less the average cost of regular footwear, as determined by Sun Life, or • $150[1], whichever is less.
Orthotics	Maximum reimbursable expense of $300[1] for each covered person in any one calendar year.
Oxygen and its administration	N/A
Private nursing care at home	Maximum reimbursable expense of $15,000[1] for each covered person in any one calendar year, as long as the care is prescribed by a physician and medically necessary. The person providing the nursing care or prescribing it: • does not live with the patient, and, • is not related to the patient by blood or marriage. Contact Sun Life ahead of time to make sure that the plan will cover the expenses.

Eligible Expenses	Limitations
Physician's services, when such services would be eligible for reimbursement under one or more provincial health plans	N/A
Trusses, crutches, splints, casts and cervical collars in metal or hard plastic	N/A
Wheelchair required for therapeutic use in the patient's private residence - rental, or purchase at Sun Life's option - including repairs and replacement	Reimbursement limited to the cost of non-motorized equipment, unless medically proven that motorized is required (no earlier than 60 months after the last purchase)
Wigs, when the patient is suffering from total hair loss as the result of a disease or illness	Lifetime maximum reimbursable expense of $500[1]

[1]All expenses with a maximum reimbursable amount will be paid at 100% coinsurance.

Life Insurance

BASIC LIFE INSURANCE

In the event of your death from any cause, your beneficiary would receive benefits equal to twice your adjusted insurable earnings to a maximum of $1,000,000.

Coverage reduces by 10% (of your full coverage in effect on your 61st birthday), beginning on the April 1st or the October 1st immediately following your 61st birthday and every year after that.

Example	
Annual earnings at age 60	$89,400
Coverage at age 60	$179,000
Birth date	March 15
10% of coverage in effect at age 61	$17,900
If no change in earnings:	
Coverage effective April 1st after the 61st birthday	$179,000 - $17,900 = $161,000
Coverage effective April 1st after the 62nd birthday	$161,100 - $17,900 = $143,200
Coverage effective April 1st after the 63rd birthday	$143,200 - $17,900 = $125,300

If you die while you are still working at NAV CANADA, coverage equals at least:

- $5,000 or
- one third of your adjusted insurable earnings on the date of your death

Benefits are not taxable when paid to the beneficiary you name (any interest paid between the date of death and the date of payment is taxable). However, if your estate receives life insurance benefits, they may be subject to probate fees, since they may be considered assets.

Basic Life Insurance Living Benefits Loan Program

If you become terminally ill with a life expectancy of 12 months or less, you may apply for a commercial loan under the Sun Life Benefits Loan Program. Under this program, you may receive an advance of up to 50% of your Basic Life coverage, to a maximum of $100,000, provided that:

- you suffer an injury or illness expected to result in death within 12 months, from which there is no reasonable prospect of recovery, based on your physician's medical information,
- you have not named an irrevocable beneficiary,
- you submit a written request to Sun Life,
- NAV CANADA authorizes the payment, and
- you and your beneficiary sign an agreement before the benefit is paid.

If you are within 5 years of a scheduled reduction of Basic Life coverage, the advance you may receive cannot exceed 50% of the lowest reduced amount of the Basic Life coverage, to a maximum of $100,000. If you are within 5 years of the termination of your Basic Life coverage, you may not apply for a commercial loan under the Sun Life Living Benefits Loan Program. This program is subject to other restrictions, as advised by Sun Life.

The amount paid (plus accumulated interest) will reduce the Basic Life Insurance benefit your beneficiary receives when you die.

SUPPLEMENTAL LIFE INSURANCE

If you have this coverage, in the event of your death from any cause, your beneficiary would receive benefits equal to your adjusted insurable earnings, rounded to the nearest multiple of $1,000 (two times adjusted insurable earnings for Senior Managers).

Coverage begins reducing by 10% (of your full coverage in effect on your 61st birthday) each year, on the first of the month following your birthday starting at age 61 (no reduction applies for Senior and Middle Managers). The minimum coverage while employed is 10% of your adjusted insurable earnings.

Example	
Annual earnings at age 60	$89,400
Coverage at age 60	$89,000
10% of coverage in effect at age 61	$8,900
If no change in earnings:	
Coverage effective April 1 after the 61st birthday	$89,000 - $8,900 = $80,100
Coverage effective April 1 after the 62nd birthday	$80,100 - $8,900 = $71,200
Coverage effective April 1 after the 63rd birthday	$71,200 - $8,900 = $62,300

Benefits are not taxable when paid to the beneficiary you name (any interest paid between the date of death and the date of payment is taxable). However, if your estate receives life insurance benefits, they may be subject to probate fees, since they may be considered assets.

You must enroll in Supplemental Life Insurance to apply for Optional Life Insurance, Accidental Death and Dismemberment Insurance and Dependent Insurance.

OPTIONAL LIFE INSURANCE

You must enroll in Supplemental Life Insurance to apply for Optional Life Insurance.

If you have this coverage, in the event of your death from any cause, your beneficiary would receive benefits equal to your adjusted insurable earnings.

Coverage begins reducing by 10% (of your full coverage in effect on your 61st birthday) each year, on the 1st of the month following your birthday starting at age 61. The minimum coverage while employed is 10% of your adjusted insurable earnings.

Example	
Annual earnings at age 60	$89,400
Coverage at age 60	$89,000
10% of coverage in effect at age 61	$8,900
If no change in earnings:	
Coverage effective April 1 after the 61st birthday	$89,000 - $8,900 = $80,100
Coverage effective April 1 after the 62nd birthday	$80,100 - $8,900 = $71,200
Coverage effective April 1 after the 63rd birthday	$71,200 - $8,900 = $62,300

Benefits are not taxable when paid to the beneficiary you name (any interest paid between the date of death and the date of payment is taxable). However, if your estate receives life insurance benefits, they may be subject to probate fees, since they may be considered assets.

DEPENDENT INSURANCE

You must enroll in Supplemental Life Insurance to apply for Dependent Insurance

If you are enrolled in this coverage, this plan pays $5,000 if your spouse dies and $2,500 if one of your children dies.

Coverage reduces to $1,250 on the first of the month following your 65th birthday (no reduction applies for Senior Managers).

A percentage of this amount is payable for certain serious injuries. Please see the Illness/Injury section for further details.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

You must enroll in Supplemental Life Insurance to apply for Accidental Death and Dismemberment Insurance.

If you have coverage under the Accidental Death and Dismemberment Insurance Plan (as part of the Management Insurance Plan) the amount payable in the event of death is as follows:

Level	Amount of Coverage
Senior Managers	$250,000
Other full-time Management employees	Units of $25,000, up to $250,000

Repatriation Benefit

If you die as the direct result of an accident 100 kilometers or more from home, Sun Life will pay for the preparation and transportation of the body for burial or cremation to a maximum of $10,000.

Claims will not be paid if they are eligible for reimbursement from other sources or another benefit of this contract.

Only reasonable and customary expenses for this service will be reimbursed.

Spouse Occupational Training Benefit

If you die as the direct result of an accident, Sun Life will pay up to $5,000 to your spouse for occupational training as long as the training is for a job your spouse was not previously qualified for. Ordinary living expenses such as room, board, travelling or clothing will not be reimbursed.

All expenses must be incurred within 3 years from the date of the accident and must be approved by Sun Life. Approval will be based on the likelihood that it will be successful. Claims will not be paid if they are eligible for reimbursement from other sources or another benefit of this contract.

Only reasonable and customary expenses connected with an occupational training program will be reimbursed.

Child Education Benefit

If you die as the direct result of an accident, Sun Life will pay 5% of the amount of coverage up to $5,000, per year to a maximum of 4 years, for your dependent child's tuition fees in a post-secondary school. Ordinary living expenses such as room, board, travelling or clothing will not be reimbursed.

Your child must enroll as a full-time student within one year of the accident.

Only reasonable and customary tuition expenses will be reimbursed.

A percentage of this coverage amount is payable for certain serious injuries. Please see the Illness/Injury section for further details.

Benefits are not taxable when paid to the beneficiary you name (any interest paid between the date of death and the date of payment is taxable). However, if your estate receives life insurance benefits, they may be subject to probate fees, since they may be considered assets.

BUSINESS TRAVEL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

If you are an active employee under age 75, live in Canada and lose your life while travelling on NAV CANADA business your beneficiary would receive 4 times the adjusted insurable earnings (to a maximum of $500,000).

If your spouse, under age 75, or one of your dependent children loses their life in a covered accident during a relocation or related house-hunting trip, you would receive the following benefit:

Spouse	$100,000
Child	$10,000

The plan also pays the following additional benefits:

- **Repatriation:** In case of death more than 150 kilometers from your permanent residence, no more than 365 days after the accident, the plan pays for preparing the deceased for burial and shipment to the city of residence of the deceased, to a maximum of $10,000.
- **Disappearance:** If the body of an insured person has not been found within one year of the disappearance, stranding, sinking or wrecking of the aircraft in which they were riding in at the time of the accident, the plan pays benefits for loss of life.

A percentage of this coverage amount is payable for certain serious injuries. Please see the Illness/Injury section for further details.

BENEFICIARY

Designating a Beneficiary

If you wish to designate one or more beneficiary, you can do so on the Basic Life – Beneficiary Designation Form by stating the beneficiary's full name and relationship to you.

You can also designate a beneficiary by will or on a subsequent beneficiary designation form.

Forms must be completed, dated and signed. You must initial any changes or alterations to the designation, no matter how small; correction fluid cannot be accepted. The signed witness on the form cannot be any of the designated beneficiaries.

Forms must be sent to the HR Employee Centre located at 77 Metcalfe (9th floor), Ottawa, Ontario, K1P 5L6.

You may designate as your beneficiary:

- any person;
- any registered charitable or benevolent organization or institution (name and registration number of the institution are required);
- any religious or educational organization (name is required);
- your estate; or
- a trust (in Quebec, the trust must be formally established).

Revocable and Irrevocable Beneficiaries

A *revocable* beneficiary means that you are free to change the beneficiary designation at any time. A beneficiary designation is assumed to be revocable, unless specifically designated as irrevocable. With exception in Quebec, the designation of a legal spouse (married or civil union) as beneficiary is irrevocable, unless specifically designated as revocable (this exception does not apply to a common law spouse).

An *irrevocable* beneficiary means you cannot change the designation without meeting specific requirements (see Changing a Beneficiary Designation below).

Changing a Beneficiary Designation

If the beneficiary designation is revocable:

A new Basic Life – Beneficiary Designation Form must be completed, dated and signed by you and a witness.

If the beneficiary designation is irrevocable:

A new Basic Life – Beneficiary Designation Form must be completed, dated and signed by you and a witness. To change an irrevocable beneficiary or to change the current beneficiary designation from irrevocable to revocable, you must also submit one of the following documents, depending on the situation:

- 'Consent by Beneficiary Form', signed by the irrevocable beneficiary, revoking their rights; or
- Divorce Certificate (in Quebec, a divorce granted after December 1st, 1982 automatically cancels the designation of the spouse as beneficiary, even if irrevocable); or
- Proof of death of the irrevocable beneficiary.

More about beneficiary designations

Designating one beneficiary:

To designate one beneficiary, you must indicate the beneficiary's name and their relationship to you on the Basic Life – Beneficiary Designation Form.

Appointing a contingent beneficiary:

A contingent beneficiary is the person designated to receive the proceeds if the primary beneficiary predeceases you. To appoint a contingent beneficiary, you must complete the Appointing Contingent Beneficiary section of the Basic Life – Beneficiary Designation Form.

Designating more than one beneficiary:

To designate more than one beneficiary, the member must indicate the name, relationship and percentage on the form for each. The total of the designated percentages must equal 100%. If percentages are not indicated, an even split will be made between beneficiaries.

If a beneficiary predeceases you, the deceased beneficiary's portion of the death benefit will be paid either to your estate or to the contingent beneficiary(ies), if designated. Remaining percentages will be paid as listed on the beneficiary forms. For example:

	Example 1	Example 2
Beneficiary 1	25%	98%
Beneficiary 2	25%	1%
Beneficiary 3	25%	1%
Beneficiary 4	25%	
	Contingent Beneficiary or Estate	Contingent Beneficiary or Estate
Note	If any of the beneficiaries predecease the member, their allocation will be split among the remaining beneficiaries. Beneficiary 1 predeceases member, Beneficiaries 2,3 and 4 get 1/3 each.	If Beneficiary 1 predeceases member, their 98% will be divided equally among the remaining beneficiaries. Beneficiary 1 predeceases member, Beneficiaries 2 and 3 get 50% each.

Quebec Residents:

In the case of an even split between beneficiaries, the percentage allocated to the deceased beneficiary will be divided equally among the surviving beneficiary(ies). In the case of an uneven split, the deceased beneficiary's portion of the death benefit will be paid to the member's estate or to the contingent beneficiary(ies) if designated. Remaining percentages will be paid as listed on the beneficiary forms. For example:

	Example 1	Example 2
Beneficiary 1	25%	98%
Beneficiary 2	25%	1%
Beneficiary 3	25%	1%
Beneficiary 4	25%	Contingent Beneficiary 1 or Estate
Note	If any of the beneficiaries predecease the member, their 25% will be split evenly between the remaining beneficiaries: Beneficiary 1 predeceases member, Beneficiaries 2,3 and 4 get 1/3 each.	If any of the beneficiaries predecease the member, their allocation will be paid to the contingent beneficiary (if designated) or the Estate: Beneficiary 1 predeceases member, Beneficiaries 2 and 3 get 1% as indicated, and the 98% goes to the Contingent Beneficiary (ies) or Estate (as per completed form on file).

Designating a minor child as beneficiary in Quebec:

In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf. If you wish to make provisions for an administrator or trustee to administer a minor child's money, you can do so in a will and designate the trustee as beneficiary. It is recommended that you consult with legal counsel to determine the estate planning steps you should take.

Designating a minor child as a beneficiary in all other provinces:

In all provinces, other than Quebec, if the member designates a minor child as beneficiary, a trustee should be designated. If no trustee is named, proceeds may be paid into court.

Designating an estate:

If you are designating your estate as beneficiary, the following should be considered:

- Insurance proceeds payable to the estate are subject to claims from creditors, whereas proceeds payable to a named beneficiary may, in some cases, be protected from creditors.
- In some instances, a will must be probated, and the costs will vary from province to province. These costs are not incurred if proceeds are payable to a named beneficiary. Probate is not required for a notarial will in the province of Quebec.

When no beneficiary has been designated:

Proceeds will be paid to the member's estate. A properly constituted and current will should be submitted with any claim to avoid delays in processing with the executors or liquidators of the estate.

MAKING A CLAIM

In the event of your death, a member of your family must notify the HR Employee Centre (HREC) at 1-888-774-4732, opt 2. They will send out the necessary forms and information to the designated beneficiary.

For all expenses under Business Travel Accidental Death and Dismemberment Insurance, contact the HR Employee Centre (HREC) at 1-888-774-4732, opt 2.

FREQUENTLY ASKED QUESTIONS

Can you show me an example of benefits payable in the case of my death?

If you earn $90,000 and enroll in both Supplemental and Optional Life Insurance, your beneficiary would receive the following benefits:

Example	
Basic Life Insurance	$180,000
Supplemental Life Insurance	$90,000
Optional Life Insurance	$90,000
Total Payable	**$360,000**

In the event of your death due to a covered accident, also having purchased $250,000 of Accidental Death and Dismemberment Insurance, your beneficiary would receive the following benefits:

Example	
Basic Life Insurance	$180,000
Supplemental Life Insurance	$90,000
Optional Life Insurance	$90,000
Accidental Death and Dismemberment Insurance	$250,000
Total Payable	**$610,000**

In the event of your death due to a covered accident while travelling on NAV CANADA business, also having purchased $250,000 of Accidental Death and Dismemberment Insurance, your beneficiary would receive the following benefits:

Example	
Basic Life Insurance	$180,000
Supplemental Life Insurance	$90,000
Optional Life Insurance	$90,000
Accidental Death and Dismemberment Insurance	$250,000
Business Travel Accidental Death and Dismemberment Insurance	$360,000
Total Payable	**$970,000**

Are the benefits tax-free?
Yes. However, if you do not name a beneficiary or name your estate as beneficiary, probate fees may apply.

How are the benefits paid?
A lump sum in Canadian dollars.

EXCLUSIONS

Basic Life Insurance

No restrictions apply to payment of this benefit.

Supplemental & Optional Life Insurance

No restrictions apply to payment of these benefits.

Dependent Insurance

No restrictions apply to payment of this benefit.

Accidental Death and Dismemberment Insurance

No benefit is payable for losses as a result of:

- self-inflicted injuries, by firearm or otherwise (including a drug overdose)
- carbon monoxide inhalation
- attempted suicide or suicide while sane or insane
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- full-time service in the armed forces of any country
- participation in a criminal offense

Business Travel Death & Dismemberment Insurance

No benefit is payable for:

- expenses paid for or furnished under the terms of any other Health Care Plan arranged through the employer,
- services provided by an agency or department of any government normally provided free-of-charge,
- non-emergency medical treatment, routine health check-ups, eye and ear examinations, eyeglasses and hearing aids, or treatment that can be reasonably delayed until return to Canada,
- dental care,
- dental services or supplies and appliances, except as previously mentioned,
- 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,
- 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 NAV CANADA, 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 three months,
- AIDS or AIDS-related disease or disorders,
- 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,
- normal commuting to and from work,
- intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane,

- full-time, active duty in the armed forces,
- injury sustained while you are performing any common, manual, or mechanical labour that may be construed as part of your regular duties for NAV CANADA,
- any accident that occurs during the period you 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, except operations requiring a ferry permit or test flight permit from the Department of Transport where such aircraft does not have a valid certificate of airworthiness and operations requiring aerial work under Transport Canada CAR 702 Operating Certificate, or
- crop dusting or spraying, seeding, firefighting, skywriting, pipeline inspection, power-line inspection, aerial photography, exploration, racing, endurance test or exhibition stunt flying.

Illness & Injury

LONG-TERM DISABILITY INSURANCE

If you are absent from work and exhaust all of your Disability Income Security Program (DISP) entitlement due to a non-work-related injury or illness you may be eligible for Long Term Disability benefits, as long as you meet the disabled criteria:

- During the elimination period and the next 24 months, you are considered disabled if you are unable to perform the essential functions of your own regular job.
- Thereafter, you are considered disabled if you are unable to perform any reasonably commensurate occupation for which you are qualified by training, education or experience.

If you do not meet the definition of disability after the elimination period and the subsequent 24 months, your benefits end, unless you participate in a rehabilitation plan.

You must be under the active care of a physician and follow a course of treatment satisfactory to Sun Life Financial.

Once your claim is approved by Sun Life Financial, you receive 70% of your adjusted insurable earnings as long as you remain disabled. This amount is reduced by amounts you receive for the same or a subsequent disability from or under:

- the Public Service Superannuation Act (PSSA) or NAV CANADA Pension Plan,
- the Canada/Quebec Pension Plan (C/QPP), excluding benefits payable to, or on behalf of, your dependents because of your disability,
- workers' compensation or similar government legislation,
- another group insurance plan or policy you have because of membership in an employee union or association,
- any government legislation, for example, automobile insurance income replacement benefits,
- disability benefits, or retirement benefits related to any employment, payable after your disability period begins,
- compensation or profit for any occupation or business enterprises in which you are actively engaged, and
- under Criminal Injuries Compensation Act, or similar law, where allowed by law.

If you are eligible for benefits from another source, you must apply for them.

Benefits are not reduced by:

- government or pension plan benefit cost-of-living increases,
- disability benefits payable to or on behalf of your dependent,
- return of pension contributions when not entitled to a pension,
- benefits from retirement plans to which NAV CANADA has not contributed,
- benefits under a private, personal insurance policy, or a policy you have because of membership in a professional association not restricted to NAV CANADA,
- severance pay,
- early departure/retirement incentives,
- rehabilitation to a maximum of 100% of monthly earnings when combined with long-term disability benefits and other offset,
- disability payments from a life insurance, or
- disability benefits to a veteran under the Pension Act, and any subsequent increases.

Example	
Annual Earnings	$67,925
Adjusted Insurable Earnings	$68,000
Gross Annual Long-Term Disability Benefits	$68,000 x 70% = $47,600
Gross Monthly Long-Term Disability Benefits	$47,600 / 12 = $3,966,67
Income from other sources	
NAV CANADA Pension Plan	$1,166.66
Canada pension Plan	$666.66
Total Income from Other Sources	$1,833.32
Monthly Net Disability Payment from the Long-Term Disability Insurance Plan	**$3,966.67 - $1,833.32 = $2,133.35**

Benefits from the Long-Term Disability Insurance Plan are taxable. Sun Life Financial sends you a tax form annually, indicating the benefits paid to you the previous year.

Your monthly Long-Term Disability Insurance Plan premiums are not tax-deductible.

Once you are receiving plan benefits however, the total premiums you paid during your employment, if applicable, are tax-deductible. You can carry the deduction over from year to year until deducted in full. Consult your local tax center for more information, and the HR Employee Centre (HREC) for total premiums you paid.

Read what exclusions apply to this coverage.

CRITICAL ILLNESS INSURANCE

You have the option to purchase Critical Illness Insurance for yourself and your eligible spouse. Coverage can be purchased in units of $25,000 up to a maximum of $250,000. Medical evidence is always required during open enrollment period, and medical evidence is required above $50,000 for new hires and qualifying life events.

Coverage can be purchased for your eligible children in units of $5,000 up to a maximum of $20,000.

Critical Illness coverage provides a benefit if, after the effective date of coverage, a diagnosis is made that the insured has experienced a covered condition or if the insured has had surgery for a covered condition as described below, subject to the survival period. The survival period is 30 days, unless a longer waiting period is specified in the definition of a covered condition.

Sun Life reserves the right to require examination of the covered person and confirmation of any diagnosis of or surgery for any covered condition, by a medical practitioner appointed by Sun Life in order for any Critical Illness benefit to become payable.

The Critical Illness benefit is payable only on the first covered condition for which a diagnosis is effective, or surgery is performed, and the insured's coverage then terminates. Such person may not be covered again under this benefit.

The Critical Illness conditions "or diagnosis" covered by this insurance plan must be diagnosed after the effective date of coverage and by a physician licensed and practicing in Canada and are defined as follows.

Read what exclusions apply to this coverage.

Covered Conditions	
Aortic Surgery	Loss of Independent Existence
Aplastic Anemia	Loss of Limbs
Bacterial Meningitis	Loss of Speech
Benign Brain Tumour	Major Organ Failure on Waiting List
Blindness	Major Organ Transplant
Cancer (Life-threatening)	Motor Neuron Disease
Coma	Multiple Sclerosis
Coronary Artery Bypass Surgery	Occupational HIV Infection
Deafness	Paralysis
Dementia, including Alzheimer's Disease	Parkinson's Disease
Heart Attack	Severe Burns
Heart Valve Replacement or Repair	Stroke (Cerebrovascular Accident)
Kidney Failure	

Sun Life offers Child Critical Illness Insurance which covers six child-specific conditions in addition to the 20 covered conditions listed above:

Covered Conditions for Children Only	
Cerebral Palsy	Down's Syndrome
Congenital Heart Disease	Muscular Dystrophy
Cystic Fibrosis	Type 1 Diabetes Mellitus

Aortic Surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Aplastic Anemia

Aplastic Anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Bacterial Meningitis

Bacterial Meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

Benign Brain Tumour

Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

The diagnosis of benign brain tumour must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Blindness

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Cancer (Life-threatening)

Cancer (Life-threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of cancer must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Coma

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

The diagnosis of coma must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Coronary Artery Bypass Surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Deafness

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of deafness must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Dementia, including Alzheimer's Disease

Dementia, including Alzheimer's disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour), which is affecting daily life.

The covered person must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period. The diagnosis of dementia must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

The diagnosis of Alzheimer's disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Heart Attack

Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms; or,
- new electrocardiogram (ECG) changes consistent with a heart attack; or,
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Heart Valve Replacement or Repair

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

The surgery must be determined to be medically necessary by a specialist physician. The covered person must survive for 30 days following the date of surgery.

Kidney Failure

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

The diagnosis of kidney failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Independent Existence

Loss of Independent Existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- Bathing: the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- Dressing: the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- Toileting: the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- Bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the use of assistive devices; and
- Feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs

Loss of Limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The diagnosis of loss of limbs must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Loss of Speech

Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

The diagnosis of loss of speech must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied,

Major Organ Failure on Waiting List

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the covered person must become enrolled as the recipient in a recognized transplant center in Canada or the United States that performs the required form of transplant surgery.

The date of diagnosis is the date of the covered person's enrolment in the transplant center.

The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Major Organ Transplant

Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the covered person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The diagnosis of the major organ failure must be made by a specialist physician. The covered person must survive for 30 days following the date of their transplant.

Motor Neuron Disease

Motor Neuron Disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The diagnosis of motor neuron disease must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Multiple Sclerosis

Multiple sclerosis means a definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or,
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of multiple sclerosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Occupational HIV Infection

Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the covered person's normal occupation, which exposed the person to HIV contaminated body fluids.

For any amount of coverage, the accidental injury leading to the infection must have occurred after the later of:

- the date the employer receives enrolment information for such amount of coverage; or,
- the effective date of such amount of coverage.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying this requirement.

Payment under this condition requires satisfaction of all of the following:

- the accidental injury must be reported to Sun Life within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist physician. The covered person must survive for 30 days following the date of the second serum HIV test described above.

Paralysis

Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of paralysis must be made by a specialist physician. The covered person must survive for 90 days following the precipitating event.

Parkinson's Disease

Parkinson's Disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The covered person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist or a specialist physician. The covered person must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Severe Burns

Severe burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

The diagnosis of severe burns must be made by a specialist physician. The covered person must survive for 30 days following the date the severe burn occurred.

Stroke (Cerebrovascular Accident)

Stroke (Cerebrovascular Accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and,
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Covered Conditions for Children Only

Cerebral Palsy

Cerebral palsy means a definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements.

The diagnosis of cerebral palsy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Congenital Heart Disease

Congenital heart disease means a definite diagnosis of at least one of the covered heart conditions described below. It also means the specific conditions described below for which open heart surgery is performed to correct the condition.

Covered heart conditions:

- coarctation of the aorta,
- Ebstein's anomaly,
- Eisenmenger syndrome,
- Tetralogy of Fallot,
- transposition of the great vessels.

The diagnosis of the heart condition must be:

- made by a specialist physician; and,
- supported by cardiac imaging acceptable to Sun Life.

The covered person must survive for 30 days following the date of diagnosis.

Covered heart conditions if open heart surgery is performed (these heart conditions are covered only if open heart surgery is performed to correct at least one of them):

- aortic stenosis,
- atrial septal defect.
- discrete subvalvular aortic stenosis,
- pulmonary stenosis,
- ventricular septal defect.

Procedures not covered by this definition are:

- percutaneous atrial septal defect closure;
- trans-catheter procedures which include balloon valvuloplasty.

The diagnosis of the heart condition must be made and the surgery must be recommended and performed:

- by a specialist physician; and,
- supported by cardiac imaging acceptable to Sun Life.

The covered person must survive for 30 days following the date of surgery.

Cystic Fibrosis

Cystic fibrosis means a definite diagnosis of cystic fibrosis where the covered person has chronic lung disease and pancreatic insufficiency.

The diagnosis of cystic fibrosis must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Down’s Syndrome

Down's syndrome means a definitive diagnosis of Down's syndrome supported by chromosomal evidence of Trisomy 21.

The diagnosis of Down's syndrome must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Muscular Dystrophy

Muscular dystrophy means a definite diagnosis of muscular dystrophy where the covered person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

The diagnosis of muscular dystrophy must be made by a specialist physician. The covered person must survive for 30 days following the date of diagnosis.

Type 1 Diabetes Mellitus

Type 1 diabetes mellitus means a definite diagnosis where the covered person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The covered person must survive for 90 days following the date of diagnosis.

DEPENDENT INSURANCE

If you have coverage under the Dependent Insurance Plan (as part of the Management Insurance Plan) and your spouse or child is injured in a covered accident, the same percentages for loss or loss of use are payable, based on a death benefit of $5,000 for your spouse and $2,500 for each dependent child (reducing to $1,250 on the first of the month following your 65th birthday. This reduction does not apply to DIR 1 employees).

Read what exclusions apply to this coverage.

Injury/Loss	Percentage of amount payable
Loss of Life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	75%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33 1/3%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four toes on the same foot	25%
Loss of use of both arms or both legs	100%
Loss of use of both hands or both feet	100%
Loss of use of one arm or one leg	75%
Loss of use of one hand or one foot	75%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

If you have coverage under the Accidental Death and Dismemberment Insurance Plan (as part of the Management Insurance Plan) and your permanent injury results from a covered accident, the amount payable for loss or loss of use is a percentage of that payable in the event of death.

Level	Amount of Coverage
Senior Managers	$250,000
Other Full-time Management Employees	Units of $25,000, up to $250,000

This percentage varies depending on the injury and/or loss. Benefits are also payable if you suffer a covered loss or loss of use because you were exposed to the elements following a covered accident.

If you are permanently injured, you may be eligible for Disability Income Security Program and Long-Term Disability Insurance benefits.

Read what exclusions apply to this coverage.

Sun Life Financial will pay the percentage, shown in the following table, of the person's amount of Accidental Death and Dismemberment coverage:

Injury/Loss	Percentage of amount payable
Loss of Life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	75%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33 1/3%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of four toes on the same foot	25%
Loss of use of both arms or both legs	100%
Loss of use of both hands or both feet	100%
Loss of use of one arm or one leg	75%
Loss of use of one hand or one foot	75%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%

Injury/Loss	Percentage of amount payable
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	25%
Quadriplegia	200%
Paraplegia	200%
Hemiplegia	200%

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. Sun Life Financial will not pay more than 100% of the amount of coverage if the person suffers from more than one of the losses in the same accident. This does not include quadriplegia, paraplegia or hemiplegia, where Sun Life Financial will pay a maximum of 200%.

Loss of an arm means that it was severed at or above the elbow. Loss of a hand means that it was severed at or above the wrist. Loss of a leg means that it was severed at or above the knee. Loss of a foot means that it was severed at or above the ankle. Loss of a thumb, finger or toes means that it was severed at or above the first joint from the hand or the foot. Loss of sight, speech or hearing must be total and permanent.

Loss of use must be total and must have continued for at least one year. Before Sun Life Financial pays the benefit, the employee must provide proof that the loss is permanent.

The following additional benefits may be paid from the Accidental Death and Dismemberment Insurance Plan in the event of loss or loss of use:

Family Transportation Benefit

If you suffer a loss as the direct result of an accident and are hospitalized at least 150 kilometers from home, Sun Life will pay up to $5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister. Sun Life will pay for car travel at a rate of $0.20 per kilometer. Transportation must be by the most direct route to and from the hospital.

Claims will not be paid if they are eligible for reimbursement from other sources or another benefit of this contract.

Only reasonable and customary expenses will be reimbursed.

Rehabilitation Program

If you suffer a loss as the direct result of an accident Sun Life will pay to $10,000 of your rehabilitation expenses. Ordinary living expenses such as room, board, travelling or clothing will not be reimbursed.

All expenses must be incurred within three years of the date of the accident and while you are covered for this benefit. Sun Life must approve the rehabilitation program, which will be based on the likelihood that it will be successful. The rehabilitation program will be made up of training required, because of the loss, to prepare you for a new occupation.

Claims will not be paid if they are eligible for reimbursement from other sources or another benefit of this contract.

Only reasonable and customary expenses connected with a rehabilitation program will be reimbursed.

Home/Vehicle Modification Benefit

If you suffer a loss as the direct result of an accident and are confined to a wheelchair, Sun Life will pay up to $10,000 for:

- one-time modifications to your principal residence to make it wheelchair accessible and habitable, and
- one-time modifications to your motor vehicle to make the vehicle accessible or drivable.

All expenses must be incurred within one year of the date of the accident and must be approved by Sun Life.

Claims will not be paid if they are eligible for reimbursement from other sources or another benefit of this contract.

Only reasonable and customary expenses will be reimbursed.

BUSINESS TRAVEL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

If you are an active employee under age 75, live in Canada and lose your life while travelling on NAV CANADA business your beneficiary would receive 4 times the adjusted insurable earnings (to a maximum of $500,000).

If your spouse, under age 75, or one of your dependent children loses their life in a covered accident during a relocation or related house-hunting trip, you would receive the following benefit:

Spouse	$100,000
Child	$10,000

The Business Travel Accidental Death and Dismemberment Insurance Plan pays benefits if you suffer a permanent injury as a result of an accident that happens during the first 60 days of travel and stopover while on NAV CANADA business, away from NAV CANADA premises. It also includes coverage:

- while a passenger, pilot or crew member, riding in, boarding or alighting from an aircraft,
- while making a parachute jump from an aircraft for the purpose of self-preservation, or
- if you are struck by an aircraft.

The amount payable for loss or loss of use is a percentage of that payable in the event of death. This percentage varies depending on the injury's severity. Benefits are also payable if you suffer a covered loss or loss of use because you were exposed to the elements following a covered accident.

Read what exclusions apply to this coverage.

Injury/Loss	Percentage of amount payable
Quadriplegia (total and irreversible paralysis of all 4 limbs)	200%
Paraplegia (total and irreversible paralysis of both lower limbs)	200%
Hemiplegia (total and irreversible paralysis of one arm and one leg on the same side of the body)	200%
Loss of both hands or both feet	100%
Loss of entire sight of both eyes	100%
Loss of one hand and one foot	100%
Loss of one hand, and entire sight of one eye	100%
Loss of one foot, and entire sight of one eye.	100%
Loss of speech and hearing	100%

Injury/Loss	Percentage of amount payable
Loss of use of both arms or both hands	100%
Loss of one arm or one leg	75%
Loss of use of one arm or one leg	75%
Loss of one hand or one foot	66 2/3%
Loss of entire sight of one eye	66 2/3%
Loss of use of one hand	66 2/3%
Loss of speech or hearing	66 2/3%
Loss of thumb and index finger of the same hand	33 1/3%
Loss of four fingers of the same hand	33 1/3%
Loss of hearing in one ear	25%
Loss of all toes on the same foot	12 1/2%

Only the largest benefit is paid for injuries resulting from one accident.

The following additional benefits may be paid from the Business Travel Accidental Death and Dismemberment Insurance Plan.

Emergency Evacuation Benefit

If injury or sickness commencing during the course of a trip results in the necessary emergency evacuation of an insured person, the plan will pay benefits for covered expenses (transportation, medical services and medical supplies incurred with the emergency evacuation) incurred by up to 10% of the amount payable in the event of death. An emergency evacuation must be ordered by a legally licensed physician who certifies that the severity of the injury or sickness warrants the emergency evacuation.

Emergency evacuation means:

- the medical condition warrants immediate transportation to the nearest hospital where appropriate medical treatment can be obtained; or
- after being treated at a local hospital, the medical condition warrants transportation to the place where the insured person resides (provided this residence is located in Canada or the United States) to obtain further medical treatment or to recover; or
- both of the above.

All transportation arrangements must be by the most direct and economical route.

Home and Vehicle Modification

If a person receives benefits for a covered loss or loss of use that requires permanent use of a wheelchair, the plan will pay up to $10,000 for one-time modifications to:

- the person's principal residence, to make it wheelchair-accessible and habitable, and
- the person's vehicle, to make it accessible or drivable, when such modifications are required by the vehicle licensing authorities,

Provided that:

- home modifications are done by an experienced contractor recommended by a recognized wheelchair support organization, and
- vehicle modifications are carried out by an experienced provider and approved by provincial licensing authorities.

Seat Belt Benefit

If a person receives benefits for a covered loss or loss of use, the amount will be increased by 10% if the person was driving or riding in a motor vehicle, wearing a properly fastened seat belt (as evidenced in a police report).

Family Transportation under the Business Travel Benefit

If you, your spouse, or child sustains a covered injury and is confined to a hospital more than 150 kilometers from home, the plan pays reasonable and customary charges to bring a member of your immediate family (that is, your legal or common-law spouse, parents, grandparents, children over age 18, brother, or sister) by the most direct route by licensed common carrier to be with the person. The attending physician must recommend this visit in writing. The maximum payable is $10,000.

Special Education Benefit

If an employee suffers loss of life in a covered accident the play will pay up to a maximum of $5,000 per year on behalf of any dependent child who, on the date of the accident, in enrolled as a full-time student in a post-secondary institution or was in their final year of secondary education and enroll as a full-time student in a post-secondary institution within 365 days following the date of the accident.

This benefit is payable annually for a maximum of four consecutive annual payments as long as the dependent child continues his/her education as a full-time student in a post-secondary institution.

If, at the time of the accident, none of the dependent children qualify, the plan will pay an additional benefit of $2,500 to the designated beneficiary.

MAKING A CLAIM

Long-Term Disability Insurance

If you become totally disabled and think your disability will last longer than the elimination period, you should claim as soon as possible. Contact the HR Employee Centre (HREC) for assistance. They will provide you with the forms you and your physician(s) must complete.

It is your responsibility to complete the Plan Member's Statement and arrange for your physician(s) to complete the Attending Physician's Statement with medical evidence supporting the diagnosis, and the prognosis. Any associated costs for completing these forms are your responsibility. Sun Life Financial adjudicates claims on the basis of all the objective medical evidence provided on your condition. Sun Life Financial may request additional information from your physician(s) or arrange for independent medical examinations.

Make sure to provide Sun Life Financial with sufficient medical proof of total disability. Omissions or unclear statements could delay your claim.

Send the completed forms directly to Sun Life Financial. To avoid delays, Sun Life Financial needs all information no later than 8 weeks prior to the completion of the elimination period.

Critical Illness Insurance

If you, your spouse and/or your child(ren) are covered under the Critical Illness Insurance Plan and have been diagnosed with one of the covered conditions you should contact a Sun Life Representative by calling 1-866-539-7678. Sun Life will advise you of the documents required by your physician to process the claim.

Benefits are not taxable when paid to the insured member.

Dependent Insurance

In the event you, your spouse or one of your children is injured, you must notify the HR Employee Centre at 1-888-774-4732, option 2. They will send out the necessary forms and information.

Accidental Death and Dismemberment Insurance

In the event you, your spouse or one of your children is injured, you must notify the HR Employee Centre at 1-888-774-4732, option 2. They will send out the necessary forms and information.

Business Travel Accidental Death and Dismemberment Insurance

For all expenses under Business Travel Accidental Death and Dismemberment Insurance, contact the HR Employee Centre at 1-888-774-4732.

FREQUENTLY ASKED QUESTIONS

Short Term Disability Benefits

Am I entitled to these benefits?

Yes, if you are a full-time or part-time management employee short-term disability benefits are paid from the Disability Income Security Program (DISP).

When am I eligible to get these benefits?

When your manager or immediate supervisor is satisfied that you are unable to perform your duties, because of non-occupational illness or injury. A medical certificate may be required.

What benefits do I get?

You receive 100% of your salary if you are eligible.

Senior Managers	100% of your base salary and applicable allowances under the DISP, for up to 39 weeks (195 working days) for any disability (including any recurrence)
All Other Management Employees	100% of your base salary and applicable allowances under the DISP, for up to 26 weeks (130 working days) for any disability (including any recurrence)

Do short-term disability benefits apply if my disability is work-related?

No. In that case, NAV CANADA pays your full salary under Injury-on-Duty Leave. These claims are adjudicated by the provincial workers' compensation authority.

What happens to my other NAV CANADA benefits coverage while I am disabled?

Your benefits continue as though you were at work.

What happens if I return to work and become disabled again?

Under the Disability Income Security Program, if you become disabled from the same or a related cause within 30 days, short-term disability benefits resume.

When do short-term disability benefits end?

When you have used your total DISP entitlement, but no later than:

- the date you retire, or
- the date you leave NAV CANADA,

whichever happens first.

How do I make a claim?

Notify your manager or immediate supervisor as soon as you are absent from work due to a non-work-related injury or illness. If the absence is expected to extend beyond 21 consecutive calendar days, your manager must complete the online Employee Notification Form.

Long-Term Disability Insurance

What is considered a disability?

During the elimination period and the next 24 months, you are considered disabled if you are unable to perform the essential functions of your own regular job. Thereafter, you are considered disabled if you are unable to perform any reasonably commensurate occupation for which you are qualified by training, education or experience.

You must be under the active care of a physician and follow a course of treatment satisfactory to Sun Life Financial.

What if my disability is related to a condition I had before starting work with NAV CANADA?

Generally, no benefits are paid for disabilities arising from a disease or injury for which you obtained medical care before you became insured. However, if you meet the following criteria, this provision does not apply to you.

If you:

- have not received medical care for the condition for a continuous period of 90 days ending on/after the date your coverage began; or,
- you have been covered under the NAV CANADA Long-Term Disability plan for at least 13 weeks and have not been treated by a doctor or other medical personnel, under the direction of a doctor, for the condition; or,
- become totally disabled more than one year after this plan begins to cover you.

When do I start benefits?

After the elimination period.

Do these benefits apply if my disability is work-related?

No. In that case, NAV CANADA pays your full salary under Injury-on-Duty Leave. These claims are adjudicated by the provincial workers' compensation authority.

Will my benefits increase when the cost of living goes up?

Yes. Plan benefits will be adjusted to reflect any cost-of-living increase each January 1st, to a maximum of 3% a year.

What are my responsibilities while on Long-Term Disability?
During any period of total disability, you must make reasonable efforts to:

- recover from the disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from the employer.
- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

If you fail to do any of these things, Sun Life may withhold or discontinue benefits.

What happens if I become disabled while I am on a leave of absence?
If you become disabled while on leave and have maintained your coverage, you would be entitled to the short-term disability. Long-Term Disability Insurance benefits would begin following the expiration of short-term disability.

What happens to my other benefit coverage while I am disabled and maintain an employee status?
Coverage under the Management Insurance Plan that you had before you became disabled continues at no cost to you while you are eligible to receive benefits from the Long-Term Disability Insurance Plan.

For Basic Life Insurance, NAV CANADA will continue to pay for management employees' coverage.

Your coverage under the Health Care and Dental Care Plans continue at no cost to you. NAV CANADA will continue to cover 100% of the cost of premiums.

Your coverage under the Critical Illness Insurance Plan will continue as long as you pay the necessary premiums. You must send post-dated cheques to the HR Employee Centre.

What happens if I return to work and become disabled again?
If you recover and return to work, and then become disabled again after:

- one month, if the second disability is due to entirely unrelated causes,
- six months, if the second disability is due to related causes, or
- twelve months, if the second disability is due to the same cause,

your Long-Term Disability Insurance benefits will start again, in the same amount as you were receiving before you returned to work, without a new elimination period.

Do I have to participate in a rehabilitation plan?
Yes. Sun Life Financial may stop your benefits if you do not co-operate or participate in a recommended and approved rehabilitation plan.

You may be able to engage in such a plan for up to 24 months while receiving long-term disability benefits from Sun Life Insurance. Your total income from an approved plan, plus disability benefits, cannot exceed your pay before you became disabled.

When do benefits end?
Your benefits end when you:

- stop being disabled,
- are no longer under the active care of a physician,
- are not following a course of treatment satisfactory to Sun Life Financial, or
- the last day of the month in which you reach age 65,

whichever comes first.

Critical Illness Insurance

What happens if I am diagnosed with more than one eligible condition?
Your coverage will end on the date a Critical Illness benefit is paid for a covered condition which you sustain. Once payment has been made, coverage is terminated for the insured individual.

Does the Critical Illness coverage provide any additional benefits?
Yes, the Critical Illness Insurance also provides you and your spouse with the services of Best Doctors.

Should you, your spouse or your dependent children be diagnosed with – or suspect they suffer from – a serious medical condition (excludes mental, nervous and chronic pain conditions (e.g. Fibromyalgia)), they will be connected with a Member Advocate, a Registered Nurse, who will be dedicated to their case and will provide support throughout the entire process, and:

- InterConsultation™ - an in-depth review of your medical files to confirm diagnosis and treatment options. The InterConsultation process can help your treating physician determine the proper course of action.
- FindBestDoc™ - a customized search of the Best Doctors' database of 50,000 specialists to refer the best qualified medical expert to help to meet your specific needs. Best Doctors will arrange a referral (access to a Canadian specialist requires a referral from a treating physician), necessary appointments and can help book accommodations if out-of-town travel is required.

- FindBestCare™ - access to hospital and doctor discounts if out-of-country care is necessary. Best Doctors will ensure vital information is sent to the medical specialist involved and will continually monitor your treatment process to help ensure their medical priorities are met. If you need to travel away from home to receive medical treatment, Best Doctors can assist with reservations and accommodations (expenses relating to FindBestDoc and FindBestCare for travel, lodging and treatments are your responsibility).
- Best Doctors 360º ™ - a unique program designed to help you navigate the healthcare system by providing one-on-one support, customized advice and guidance personally delivered to each covered person.

Please Note: Best Doctors is not an agent, representative or service provider of Sun Life. All representations about the services of Best Doctors are those of Best Doctors Inc., and not Sun Life. Sun Life cannot guarantee the availability of Best Doctors services and reserves the right to cancel Best Doctors at any time.

Can I keep the Critical Illness Insurance when I leave/retire from NAV CANADA?
Yes, should you leave NAV CANADA you have 31 days to contact Sun Life and request a conversion of the Critical Illness Insurance to a private plan without providing a proof of health. You cannot convert more coverage then you currently have as an employee up to a maximum of $100,000. This option is not available for child coverage.

Dependent Insurance

Are the benefits tax-free?
Yes.

How are the benefits paid?
A lump sum in Canadian dollars.

Can you show me examples of how coverage works?

Loss or Loss of use of dependent	You would receive...
If your spouse loses a leg	75% x $5,000 = $3,750
If your child loses hearing in one ear	25% x $2,500 = $625

Accidental Death and Dismemberment Insurance

Are the benefits tax-free?

Yes.

How are the benefits paid?

A lump sum in Canadian dollars.

Can you show me examples of how coverage works?

Assuming you have $250,000 of coverage	You would receive...
If you lose an arm	75% x $250,000 = $187,500
If you lose four toes on the same foot	25% x $250,000 = $62,500

Even if the accident results in multiple injuries, the plan pays only for the loss or loss of use that provides the largest amount:

If you lose an arm and hearing in one ear	You would receive...
Loss of arm	75% x $250,000 = $187,500
Loss of hearing in one ear	25% x $250,000 = $62,500
Actual benefit payable	$187,500

EXCLUSIONS

Long-Term Disability Insurance

Sun Life Financial will not pay benefits for any period:

- the employee is not receiving appropriate treatment.
- the employee does any work for wage or profit except as approved by Sun Life Financial.
- the employee is not participating in an approved partial disability or rehabilitation program, if required by Sun Life Financial.
- the employee is on a strike except where specifically agreed to by Sun Life Financial.
- the employee is absent from Canada longer than 4 months due to any reason, unless Sun Life Financial agrees in writing in advance to pay benefits during the period.
- the employee is serving a prison sentence or is confined in a similar institution.

Sun Life Financial will not pay benefits if an employee's disability results directly or indirectly from a condition which existed on or before the date the employee's coverage began. However, this limitation will not apply to the employee if:

- the employee has not had medical care for the condition for a continuous period of 90 days ending on or after the date the employee's coverage began, or

- the employee has been covered for Long Term Disability with the employer for at least 13 continuous weeks during which the employee has been actively working (up to 3 days of absence does not count) and the employee has not been treated by a doctor, or any medical personnel under the direction of a doctor, for the condition, or
- the employee became totally disabled more than 1 year after the employee's coverage began. If coverage ends due to a lay-off, Sun Life Financial will consider any period of work before the lay-off towards fulfilling this limitation.

If the employee's coverage ends and the employee is covered again under this contract, Sun Life Financial will use the latest date the employee's coverage began when applying the above limitation, except otherwise indicted above.

Sun Life Financial will not consider the employee totally disabled if the employee's disability results from drug or alcohol abuse. However, this limitation will not apply while the employee is participating in a Sun Life Financial approved treatment program or the employee has an organic disease which would cause total disability even if drug and alcohol abuse ended.

Sun Life Financial will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offense.

Critical Illness Insurance

- No benefit is payable for any illness, disorder or surgery not specifically defined under Covered Conditions.
- No benefits are payable for claims resulting directly or indirectly from any of the following:
    - intentionally self-inflicted injuries or attempted suicide, while sane or insane;
    - the hostile action of any armed forces, insurrection or participation in a riot or civil commotion;
    - participation in a criminal offence;
    - use of illegal or illicit drugs or substances, misuse of drugs or alcohol;
    - the death of the Insured during the required survival period (varies by covered condition).
- No benefit is payable once you retire or reach age 70, whichever is earlier.
- Lump sum payments will not be paid for any additional critical illnesses after the date a Critical Illness benefit is paid for a covered condition which you sustain.

Pre-existing Conditions

For any coverage that did not require proof of good health, no benefits are payable for any covered condition that:

- occurs within 12 months of the effective date of the covered person's coverage, and
- that resulted from any injury, sickness or medical condition (whether or not diagnosed during the 12 months prior to the effective date of the covered person's coverage) for which:
    - the covered person had symptoms,
    - consulted a physician or other health care practitioner,
    - was provided any health-related care, advice or treatment, or
    - that a reasonably prudent person with such injury, sickness or medical condition would have consulted a physician or any other health care practitioner.

If coverage ends but the person is covered again under this benefit, we will use the latest date the person's coverage began when applying the above limitation. This exclusion does not apply where the Child moratorium period exclusion applies or to any child of the employee or the employee’s spouse who is born or adopted later than 10 months after the date the employee becomes covered for Child Critical Illness.

Child Moratorium Period Exclusions

Any child of you or your spouse will be excluded from Critical Illness coverage if:

- that child was born within the 90-day period prior to the date you obtain Child Critical Illness coverage; or,
- that child is born on or within 10 months after the date you obtain Critical Illness coverage for your existing children,

and, before or within 90 days after that child's birth:

- that child is diagnosed with any covered condition; or,
- that child has any signs, symptoms or investigations that lead to a diagnosis of a covered condition within 5 years of the child's birth.

Aortic Surgery

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Bacterial Meningitis

No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour Exclusions

- No benefit will be payable under this condition for pituitary adenomas less than 10 mm.
- No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Benign Brain Tumour Moratorium Period Exclusions

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of benign brain tumour (covered or excluded under this coverage),

no benefit will be payable for benign brain tumour for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for benign brain tumour for those additional amounts. All other coverage remains in force.

This information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

Cancer (Life-threatening) Exclusions

No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

No benefit will be payable under this condition for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukaemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Cancer Moratorium Period Exclusions

If, within 90 days following the later of:

- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under this coverage),

no benefit will be payable for cancer for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for cancer for those additional amounts. All other coverage remains in force.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

For the purposes of this benefit, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For the purposes of this benefit, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Coma Exclusions

No benefit will be payable under this condition for:

- a medically induced coma; or,
- a coma which results directly from alcohol or drug use; or,
- a diagnosis of brain death.

Coronary Artery Bypass Surgery

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Dementia, including Alzheimer's Disease

No benefit will be payable under this condition for affective or schizophrenic disorders or delirium.

For purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack Exclusions

No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or,
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described in the Critical Illness section under Illness/Injury.

Heart Valve Replacement or Repair

No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Loss of Speech Exclusions

No benefit will be payable under this condition for any psychiatric related causes.

Occupational HIV Infection Exclusions

No benefit will be payable under this condition if:

- the covered person has elected not to take any available licensed vaccine offering protection against HIV; or,
- a licensed cure for HIV infection has become available prior to the accidental injury; or,
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Parkinson’s Diseases Exclusions

Parkinson's Disease Moratorium Period Exclusion

If, within 1 year following the later of:

- the date Sun Life receives enrolment information for any amount of coverage; or
- the date the employer receives enrolment information for any amount of coverage; or
- the effective date of such amount of coverage,

the covered person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson’s disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage), regardless of when the diagnosis is made; or
- a diagnosis of Parkinson’s disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this coverage),

no benefit will be payable for Parkinson’s disease or specified atypical parkinsonian disorders for such amount of coverage. In addition, if the person subsequently becomes covered for additional amounts of coverage, no benefit will be payable for Parkinson’s disease or specified atypical parkinsonian disorders for those additional amounts. All other coverage remains in force.

No benefit will be payable under Parkinson's disease and specified atypical parkinsonian disorders for any other type of parkinsonism.

The information described above must be reported to Sun Life within 6 months of the date of diagnosis. If this information is not provided, Sun Life has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the Moratorium Period Exclusion.

Stroke (cerebrovascular accident) Exclusions

No benefit will be payable under this condition for:

- transient ischemic attacks; or,
- intracerebral vascular events due to trauma; or,
- lacunar infarcts which do not meet the definition of stroke as described in the Critical Illness section of Illness/Injury.

Dependent Insurance

No restrictions apply to payment of Dependent Insurance benefits.

Accidental Death and Dismemberment Insurance

Benefits are not payable if the loss or loss of use results from (or is associated with):

- self-inflicted injuries, by firearm or otherwise (including a drug overdose),
- carbon monoxide inhalation,
- attempted suicide or suicide while sane or insane,
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion,
- full-time service in the armed forces of any country,
- participation in a criminal offense.

Business Travel Accidental Death and Dismemberment Insurance

No benefit is payable for:

- expenses paid for or furnished under the terms of any other Health Care Plan arranged through the employer,
- services provided by an agency or department of any government normally provided free-of-charge,
- non-emergency medical treatment, routine health check-ups, eye and ear examinations, eyeglasses and hearing aids, or treatment that can be reasonably delayed until return to Canada,
- dental care,
- dental services or supplies and appliances, except as previously mentioned,
- 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,
- 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 NAV CANADA, 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 three months,
- AIDS or AIDS-related disease or disorders,
- 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.
- normal commuting to and from work,

- intentionally self-inflicted injuries, suicide or any attempt thereat, while sane or insane,
- full-time, active duty in the armed forces,
- injury sustained while you are performing any common, manual, or mechanical labour that may be construed as part of your regular duties for NAV CANADA,
- any accident that occurs during the period you 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, except operations requiring a ferry permit or test flight permit from the Department of Transport where such aircraft does not have a valid certificate of airworthiness and operations requiring aerial work under Transport Canada CAR 702 Operating Certificate; or
- crop dusting or spraying, seeding, firefighting, skywriting, pipeline inspection, power-line inspection, aerial photography, exploration, racing, endurance test or exhibition stunt flying.

Making a Claim

In provinces with a program to cover expenses also covered under the NAV CANADA Health Care Plan (for example, prescription drugs, artificial limbs and other assistive devices, dental services, etc.), first, submit your claim to the province. Then, submit any eligible expenses remaining under the Health Care Plan.

Submitting a Claim

If you are covered under the Health Care Plan you can submit your claims for certain services electronically. All other services must be submitted by paper claim form.

Mobile

1. Go to Sun Life Mobile.
2. Sign in with your Access ID and password.
3. Click on Submit a Claim.
4. Select on the appropriate option.

Online

1. Go to www.mysunlife.ca/navcanada.
2. Sign in with your Access ID and password.
3. Click on My claims.
4. Select the appropriate option under the Submit a claim section.

You can get an Access ID and password by calling Sun Life at 1-800-361-6212 or by clicking "Register now" on the sign-in page.

Paper Claim Form

1. Pay the expense and get a receipt.
2. Complete the appropriate form(s).
3. Mail both the claim form and original receipt to Sun Life.

Coordination of Benefits

If you and your spouse are covered by more than one Benefit Plan, you may be able to claim up to 100% of eligible expenses, depending on what is eligible under your spouse's plan. You can also coordinate benefits if you and your spouse both work for NAV CANADA and both have family coverage.

Always submit expenses first to the plan that covers you as a full-time or part-time employee (if, for example, you are covered under another plan as a spouse or retiree).

For expenses incurred by...	Submit your claim...
You	1. To your NAV CANADA plan 2. To your spouse's plan, if a balance remains
Your Spouse	1. To your spouse's plan 2. To your NAV CANADA plan, if a balance remains
Your Children	1. To the plan of the parent whose birthday falls earlier in the year (if both parents have the same birth date, to the plan of the parent whose surname begins with the first letter in the alphabet) 2. To the plan of the other parent, if a balance remains

If you are separated or divorced and are claiming for your children

Claims must be processed in the same order as if you have shared custody of your children. As long as you are the legal parent of the child, you can process his or her claims.

Claims must be submitted first to the plan of the parent with primary custody, then, to the plan of the other parent, if a balance remains.

Claim Submission Deadlines

Health Care Plan

Expense claims must be received by Sun Life no more than 90 days after:

- the end of the year in which the expense is incurred, or
- termination of coverage.

Dental Care Plan

- Orthodontic expense claims must be received by Sun Life no more than 15 months after the date of each monthly visit throughout the treatment period.
- Other expense claims must be received by Sun Life no more than 15 months after the date of treatment.

Checking Health & Dental Claims Status

Call the Sun Life toll-free customer service number and select the option “Medical and Dental Claims Information”, Monday through Friday 7 am to 8 pm, Eastern Standard Time, at 1-800-361-6212.

Alternatively, go online to the Sun Life Member Services web site at www.mysunlife.ca/navcanada using your Access ID and PIN. You can get an Access ID and PIN number by calling Sun Life at the above number.

APPEALS

Health Care, Dental Care, and Long-Term Disability Insurance Claims

You must submit a written request for a review to Sun Life Financial. If you do not agree with the review decision, contact the HR Employee Centre (HREC) at 1-888-774-4732, option 2 or HREC-CERH@navcanada.ca.

Critical Illness Insurance Claims

You must submit a written request for a review to Sun Life Financial. If you do not agree with the review decision, you have access to Sun Life Financials' Ombudsman, whose role is to review the claims decision-making process for adherence to proper practices and procedures, share their findings with the Claims office, and then communicate the results of the review to the Plan Member. To contact the Critical Illness Insurance representatives, call 1-866-539-7678.

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 a resident in the patient's home or 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.
- 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 practicing in Canada where eligible to be covered under a provincial health plan, unless such services are specifically included.
- Services or supplies payable or available (regardless of any waiting list) under any government sponsored plan or program unless explicitly listed as covered under the benefit.
- Services or supplies that are not approved by Health Canada or another government regulatory body for the general public.
- Services or supplies that are not generally recognized by the Canadian medical standards.
- Services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- The portion of charges that is the legal liability of any other party.
- 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, when covered by a provincial health plan.
- 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 utilization of semi-private accommodation.
- 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.
- Vitamins (except injectables), minerals and protein supplements, unless specifically included.
- Therapeutic nutrients, unless specifically included.
- 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.
- Brand-name drugs, unless Sun Life has approved the exception request, or no generic equivalent drugs are available on the market.
- Drugs that are used for cosmetic purposes.
- Weight-loss drugs (includes injectable vitamins and dietary supplements prescribed by a physician in conjunction with a weight loss drug program) unless the covered person is deemed obese as defined by the World Health Organization (WHO).
- Drugs that are used for a condition or conditions not recommended by the manufacturer.
- Prescribed drugs that can be purchased over the counter.
- Items purchased primarily for athletic use.
- The regular treatment of an injury or disease that existed prior to your dependent's departure, or your departure, from your province of residence.
- Benefits which are legally prohibited by the government from coverage.
- Surgical supplies and diagnostic aids.
- Services that are not immediately required or which could reasonably be delayed until the person returns to the province where the person lives, unless their medical condition reasonably prevents the person from returning to that province prior to receiving the medical service.
- Services relating to an illness or injury which caused the Emergency, after such Emergency ends.
- Continuing services arising directly or indirectly out of the original Emergency or any recurrence of it, after the date that the Plan Administrator or Allianz Global Assistance, based on available medical evidence, determines that the person can be returned to the province where the person lives, and the person refuses to return.
- Services which are required for the same illness or injury for which the person received Emergency Services, including any complications arising out of that illness or injury, if the person had unreasonably refused or neglected to receive the recommended medical services.
- Where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or an emergency arising directly or indirectly out of that illness or injury.
- Any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.
- The portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program.
- Dental expenses, other than those indicated as Eligible Expenses.
- Expenses for repairs or replacement of purchased durable equipment.

Forms

CLAIM FORMS

Type of Expense	Form Name	Purpose
Health Care	Extended Health Care and Health Spending Account Claim Form	Use this form when you want to submit a health care claim under your Health Care Plan or Health Spending Account
Dental Care	Dental and Health Spending Account Claim Form	Use this form when you want to submit a dental claim under your Dental Care Plan or Health Spending Account

PRIOR APPROVAL FORMS

Type of Form	Form Name	Purpose
Brand Name Exception	Drug Exception Application Form	Use this form when you want to request approval for coverage
Disabled Child	Disabled Child Approval Form	Use this form to request continuation of coverage for your child, who depends on you for support because of a psychiatric or physical disability and became disabled before age 21

EMERGENCY TRAVEL FORMS

Type of Plan	Form Name	Purpose
Travel to Cuba	Letter providing proof of Travel Insurance	Travelers to Cuba are required to provide proof of travel insurance prior to be granted entry into the country

APPLICATION & BENEFICIARY FORMS

Type of Plan	Form Name	Purpose
Basic Life Insurance Plan - Beneficiary Designation	Basic Life Insurance Plan Naming or Substitution of Beneficiary	Use this form to nominate or change a beneficiary for your Life Insurance benefits
Management Insurance Plan - Application and Beneficiary Designation	Management Insurance Plan Application and Naming or Substitution of Beneficiary	Use this form to apply for and/or nominate or change a beneficiary for your Management Insurance Plan Benefits
Health Statement Form	Health Statement Form	Use this form to provide proof of good health when applying for Critical Illness Insurance (amounts over $50,000) and Management Insurance Plan Benefits
Business Travel AD&D - Beneficiary Designation	Business Travel AD&D Naming or Substitution of Beneficiary	Use this form to nominate or change a beneficiary for your Business Travel AD&D benefits

Glossary

Actively at Work

An employee is actively at work on any day during which they perform all the usual and customary duties of their occupation with NAV CANADA for the scheduled number of hours that day.

You are deemed to be actively at work:

- on a scheduled non-working day if you were actively at work on your last scheduled working day, or
- on the effective date, for the benefits provided by this Plan, which are comparable to the benefits for which you were covered under another group plan with NAV CANADA, provided:
    - your coverage terminated solely as a result of the termination of benefits under that plan, and
    - the effective date of this plan is within 31 days following such date of termination.

Acupuncturist

A person licensed, registered or certified through the respective provincial licensing body or professional organization, or in the absence of such an association, person with comparable qualifications determined by Sun Life.

Adjusted Insurable Earnings

For Supplemental and Optional Life Insurance, your annual earnings, rounded to the nearest multiple of $1,000, if not already such a multiple.

For all other plans, your annual earnings, rounded up to the next higher multiple of $250, if not already such a multiple.

All life insurance coverage that must be multiplied by two will be rounded after the multiplication.

Annual earnings include your base salary and the General Allowance.

Appropriate Treatment

Any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Basic Services

Dental services such as exams, X-rays, fillings, root canals, treatment of gum disease, dental surgery and dental injuries as the result of an accident.

Certain Health Practitioners
Acupuncturist, chiropodist/podiatrist, chiropractor, naturopath, osteopath, physiotherapist, psychologist and registered massage therapists

Child/Children
Your unmarried children, and children in the custody of your spouse who lives with you, including adopted children, stepchildren, foster children, or children for whom you are or your spouse is the legal guardian, and who are:

- under age 21,
- age 21 or older and dependent on you for support because of a psychiatric or physical disability, provided they become disabled while eligible (or while they would have been eligible if you had been covered) under the benefit program, or
- age 21 or older, but under age 25 (age 26 for children of employees residing in Quebec) and who is a full-time student attending an educational institution recognized under the *Canadian Income Tax Act* and is entirely dependent on you for financial support.

Under the Health Care and Dental Care plans a child is considered under age 21, 25, or 26 until the first day of the month immediately following the month in which he or she reaches that age.

Chiropodist/Podiatrist
A person licensed by the appropriate provincial licensing authority or, in those provinces where there is no licensing authority, a member 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.

Chiropractor
A member of the Canadian Chiropractic Association or of a provincial association affiliated with it or, in the absence of such an association, person with comparable qualifications determined by Sun Life.

Chronic Disease
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 six months may be considered chronic.

Commensurate Occupation
A position for which the rate of pay is at least two-thirds of the current rate of pay of the position you occupied when you became disabled.

Continuous Employment

Under the Health Care Plan
For the purpose of completion of six months of continuous employment, two periods of employment, provided that the break (termination of employment) between the two periods is less than seven working days.

Under the Basic Life Insurance Plan
For the purpose of completion of six months of continuous employment, two periods of employment, provided that the break (termination of employment) between the two periods is less than one day.

Under the Dental Care and Long-term Disability Insurance Plans
For the purpose of completion of six months of continuous employment, two periods of employment, provided that the break (termination of employment) between the two periods is less than five working days.

Deferred Pension

A pension based on service and earnings on the date you leave NAV CANADA that becomes payable at a later date. When you leave before being entitled to an immediate pension, your NAV CANADA pension can be deferred.

Dental Fee Guide

Charges established by provincial dental associations for specific services provided by dentists in their provinces.

Dentist

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.

Diagnosis (Critical Illness)

Diagnosis means a written diagnosis by a physician or specialist physician, licensed and practicing in Canada, of the covered condition. Any diagnosis will be effective as of the date it is established by the physician or specialist physician, as supported by the covered person's medical records. Any diagnosis of a covered condition that was made prior to the effective date of coverage will not be covered.

Disabled/Disability

The inability, for the elimination period and the next 24 months, to perform the essential functions of your regular job (your own occupation); thereafter, the inability to perform any reasonably commensurate occupation for which you are qualified by training, education or experience (any occupation).

Electrologist

A person who, as determined by Sun Life, qualifies as a certified electrologist.

Elimination Period
The waiting period before you are eligible to receive Long-Term Disability benefits. It is 26 weeks (130 working days) for all management employees, with the exception of DIR 1 employees, who have 39 weeks (195 working days).

Emergency
Acute unexpected condition, disease or injury that requires immediate assistance.

Full-time Employee
A person who is employed for an indeterminate period or for a term of more than six months, or who has completed six months of continuous employment and works an average of at least 30 hours a week.

Health Care Plan
Includes:

- Ambulance
- Emergency Travel
- Health Practitioners
- Health Spending Account
- Hearing Aids
- Hospital
- Medical Supplies
- Prescription Drugs
- Vision

Hospital
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 specialized 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.

Life Support
Life support means the covered person is under the regular care of a licensed physician or specialist physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Licensed Pharmacist
A person who is licensed to practice pharmacy and who is listed in the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Loss

Losses of must be suffered within one year of the date, and occur as a direct result, of the accident, and include:

- hand or foot: actual severance through or above the wrist or ankle joint,
- arm or leg: actual severance through or above the elbow or knee joint,
- eye: the total and irrecoverable loss of sight,
- speech: the total and irrecoverable loss of speech that does not allow audible communication in any degree,
- hearing: the total and irrecoverable loss of hearing that cannot be corrected by any hearing aid or device,
- thumb and index finger: actual severance through or above the first phalange,
- fingers: the actual severance through or above the first phalange of all four fingers of the same hand,
- toes: the actual severance of both phalanges of all toes of the same foot, or
- 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): the complete and irrecoverable paralysis of such limbs.

Loss of Use

The total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent.

Major Services

Dental services such as crowns, bridges, and dentures, as well as orthodontics.

Management and Confidential Staff

Management employees at the P1, P2 and P3 levels.

Maximum Reimbursable Expense

To determine the maximum amount payable the reimbursable amount is calculated as follows:

Claim Amount	$180
Reimbursement Level	100% x $180 = $180
Maximum for specific claim in any one calendar year	$150
Reimbursement amount	$150

Medical Care

Care obtained when you consult a physician, use medication on the advice of a physician, or receive other medical services or supplies.

Middle Manager

Management employees at the L1 and L2 levels.

Naturopath
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.

Nurse
A registered nurse or nursing assistant, licensed, registered, or certified through the respective provincial licensing body or professional organization or, in the absence of such a registry, a nurse with comparable qualifications as determined by Sun Life.

Ophthalmologist
A doctor of medicine (M.D.) licensed to practice ophthalmology.

Optometrist
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.

Osteopath
A person licensed, registered or certified through the respective provincial licensing body or professional organization or, in the absence of such an association, a person determined by Sun Life to have comparable qualifications.

Part-time Employee
A person who is employed for an indeterminate period or for a term of more than six months, or who has completed six months of continuous employment and is assigned to work more than one-third of the normally scheduled hours of work for a particular occupational group but less than 30 hours a week.

Pension Eligibility Service
Membership in the NAV CANADA Pension Plan, used to determine when you can retire, that is, the time elapsed from the date you joined the plan, including periods of absence.

Per Script
A fee charged by the Health Care Plan for each Drug Identification Number (DIN) claimed on an individual receipt if expense not purchased at a Preferred Pharmacy.

Physician
A doctor of medicine (M.D.) legally licensed to practice medicine.

Under Critical Illness Insurance
Physician means a legally and professionally qualified medical practitioner practicing in Canada. The physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Physiotherapist
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 determined by Sun Life to have comparable qualifications.

Pro-rated
If your coverage under the Health Care Plan starts part-way through the year, Health Spending Account credits are allocated in the amount of $187.50 for each calendar quarter (January to March, April to June, July to September, and October to December).

Psychologist
A permanently certified psychologist who is listed in the appropriate provincial registry in the province where the service is rendered or, in the absence of such a registry, a person determined by Sun Life to have comparable qualifications.

Reasonable and Customary
Within the general level of charges for a specific service or product in the locale where the expense is incurred, determined by Sun Life after consulting published fee guides of associations of practitioners.

Recurrence
An absence is considered to be continuous if it is due to a recurrence of the same or related illness within any thirty (30) day period.

Registered Massage Therapist
A person licensed by the appropriate provincial licensing body or, in the absence of a provincial licensing body, a person determined by Sun Life to have comparable qualifications.

Rehabilitation
Vocational training, a program, or a period of work approved in writing by Sun Life as a means of facilitating your return to work following disability.

Retiree
Under Basic Life Insurance
A NAV CANADA employee who had at least two years of service with NAV CANADA on his or her retirement date and is receiving NAV CANADA pension benefits.

Under the Health Care Plan
A NAV CANADA employee who leaves NAV CANADA before September 1, 2005, with at least two years of service on his or her retirement date, and is receiving NAV CANADA pension benefits.

A NAV CANADA management employee who leaves NAV CANADA on or after September 1, 2005 and who, on his or her retirement date:

- is eligible for an immediate pension benefit, and
- has at least 15 years of pension eligibility service.

Must be in receipt of NAV CANADA pension benefits.

Senior Manager

Management employees at the L3, L4, VP and CEO levels.

Specialist Physician

Specialist physician means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist physician, and as approved by Sun Life, a condition may be diagnosed by a qualified medical practitioner practicing in Canada. The specialist physician providing the diagnosis or treating the covered person must not be the covered person, a relative of the covered person, or a person who normally resides in the covered person's household.

Speech-Language Pathologist

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 Association of Speech-Language Pathologists and Audiologists or any provincial association affiliated with or, in the absence of such an association, a person determined by Sun Life to have comparable qualifications.

Spouse

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.

Your spouse must be under age 75 to be covered under Business Travel Accidental Death and Dismemberment Insurance or under age 65 to be covered under Critical Illness Insurance.

Supplementary Coverage

Coverage under the Health Care Plan that supplements provincial health care coverage for eligible NAV CANADA employees and retirees who are eligible for coverage under a provincial plan.

Surgery

Surgery means a medical operation performed on the covered person and recommended by a physician or specialist physician, licensed and practicing in Canada.

Survival Period (Critical Illness)

Survival period means the period starting on the date of diagnosis of the critical condition and ending 30 days following the date of diagnosis of the critical condition, unless a covered condition expressly modifies this definition. The survival period does not include the number of days on life support. the covered person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.

Transportation

Any land, water, or air conveyance required to transport you during an emergency evacuation.

Vehicle

A private passenger car, station wagon, van, or jeep-type automobile.

Important Legal Notice

Benefits Online outlines and highlights general provisions and coverage under NAV CANADA Benefit Plans.

This information is as accurate and reliable as possible. There is no guarantee, however, that it is complete or current at all times.

- Final interpretation is governed by the terms of official contracts. In case of conflict between the content of this booklet and the relevant contract, the contract will prevail.
- Eligibility criteria and/or plans, programs, practices, and processes may be changed or terminated anytime without notice to participants.

This booklet does not constitute a contract of employment between you and NAV CANADA, or an obligation by NAV CANADA to maintain any particular benefit program, practice, or policy. NAV CANADA is not responsible for decisions you make based on this information.

NAV CANADA collects, uses and discloses personal information and personal health information (Information) about you and your dependents to arrange for the benefits described in Benefits Online. Service, insurance, and benefit providers, consultants, plan administrators, and auditors may change from time to time and receive your personal information, as required.

Protecting your privacy is important to NAV CANADA. NAV CANADA and its service and insurance providers who have job-related need to do so, collect, use, disclose, and share personal information. This Information may be used for the purpose of:

- assessing eligibility,
- providing benefits coverage to you and your dependents,
- managing and administering the plans described,
- determining which service and insurance providers to retain, and
- determining and maintaining appropriate financial terms.

Privacy policies for our insurance providers can be found at the following websites:

- Sun Life: www.mysunlife.ca
- AIG: https://www.aig.ca/privacy-principles

Access to your Information is limited to people who need to see it to achieve these purposes, or any other person whom you authorize in writing. NAV CANADA agrees to protect and maintain the confidentiality of your information through appropriate security measures and safeguards. NAV CANADA ensures all such parties enter into confidentiality agreements to protect and appropriately safeguard your information.

You are entitled to review your information and, if appropriate, have it corrected. To do so, submit a written request to HREC-CERH@navcanada.ca.

For questions on premium deductions, eligibility and coverage dates, application procedures, or claims procedures, contact the HR Employee Centre (HREC).

You have the right, upon request, to obtain a copy of the policies, your application and any written statements or other records you have provided to Sun Life as evidence of insurability, subject to certain limitations.

Every action or proceeding against an insurer for the recovery of insurance money payable under the benefits contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. Limitations Act, 2002 in Ontario, Quebec Civil Code).

You have the right to appeal a denial of all or part of the insurance or benefits described in the Basic Life, Management Insurance Plan, Long-Term Disability and Critical Illness contracts as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

If benefits are paid that were not payable under the Basic Life, Management Insurance Plan, Long-Term Disability or Critical Illness policy, you are responsible for repayment within 30 days of Sun Life sending you a notice of the overpayment, or within a longer period if agreed to in writing by Sun Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Sun Life's right to use other legal means to recover the overpayment.