Sun Life Financial

your group benefits

Health Sciences North

CUPE
(Active and Early Retirees)

Group Policy No. 101180-003
Group Plan No. 78180-003 and 012

Effective March 1, 2019
Issued April 11, 2019

Health Sciences North

Life, Optional Life and Long Term Disability Insurance
Underwritten by: Sun Life Assurance Company of Canada

Group Policy No. 101180

Extended Health and Dental Benefits
Administered by: Sun Life Assurance Company of Canada

Group Plan No. 78180

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Your Group Insurance Booklet

Keep in a safe place

This booklet is a valuable source of information for you and your family. It provides the information you need about the group benefits available through your employer's group plan with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies. Please keep it in a safe place. We also recommend that you familiarize yourself with this information and refer to it when making a claim for group benefits.

The contract holder, Health Sciences North, has entered into an Administrative Services Contract with Sun Life for the following benefits:

- Extended Health
- Dental

The contract holder has the sole legal and financial liability for these benefits and Sun Life only acts as administrator.

All other benefits are insured by Sun Life.

Your Plan Administrator is there to help

Your plan administrator can:

- help you enrol in the plan
- provide you with the forms you need to claim group benefits
- answer any questions you may have

Benefits and claims information at your fingertips

For more information about your group benefits or claims, please call Sun Life's Customer Care Centre toll-free number at 1-800-361-6212.

We're on the Internet!

Learn more by surfing Sun Life's website. There's information about group benefits, and about Sun Life's products and services... and a whole lot more! Check us out!

Our address is:

www.sunlife.ca

Accessing your records

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the policy.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Sun Life Financial Customer Care centre by calling toll-free at 1-800-361-6212.

The statements in this booklet are only a summary of some of the provisions in the master plan. If you need further details on the provisions which apply to your group benefits you must refer to the master plan (available from your plan administrator).

General Information

Eligibility for Active Employees

You are eligible, and continue to be eligible, to be a member while you meet all of the following conditions:

1. You are actively working for Health Sciences North or one of its participating affiliates.
2. You regularly work for Health Sciences North or one of its participating affiliates at least 30 hours each week.
3. You have been continuously employed by Health Sciences North or one of its participating affiliates at least as long as the waiting period.
4. You are a resident of Canada.

Participation is compulsory for Basic Life Insurance and Long Term Disability Insurance.

If you are classified as an independent, owner-operator, consultant, or if you are self-employed, you are not eligible to join the plan.

Waiting Period:

- Long Term Disability Insurance – 6 months
- All other benefits – 3 months

You are eligible, and continue to be eligible, for dependant coverage while you meet all of the following conditions:

1. You are a member.
2. You have at least one dependant.
3. Your dependants are residents of Canada.

Eligibility for Retired Employees

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

1. You are a member immediately before your date of retirement.
2. You are under age 65.
3. You are a resident of Canada.

Portability

As an eligible person, you become a member on the date you are scheduled to begin actively working if you were a member who terminated employment with your employer or with a hospital that is in the Ontario Hospital Association group of hospitals and you are employed by the employer within six months of your termination date. If, due to illness or injury, you are not actively working on that date, the insurance will not take effect until the day you have been actively working on the immediately preceding 7 consecutive working days for full time employees. You must apply for reinstatement within 31 days of the date he becomes eligible, otherwise you will be required to submit evidence of insurability to Sun Life.

Definitions

Continuous service

means a period of unbroken employment with a Participating Employer from the date of employment plus any additional eligible service as a result of a transfer from another Participating Employer. The period will include

1. vacation days and holidays granted by participating employers,
2. approved leaves of absence
3. temporary layoffs
4. interruptions of service approved by Sun Life

Dependant

means your spouse or a dependent child of you or your spouse. If Sun Life does not approve evidence of insurability required for a dependant, he will not be an insured dependant.

Dependent child

means an unmarried natural, adopted, or step-child (including children for whom you or your spouse have been appointed the legal guardian) who is entirely dependent on you for maintenance and support and who is

1. under 21 years of age,
2. under 25 years of age and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

Evidence of Insurability and Insurability

relates only to the Provisions described in Section 1 of this booklet.

He, his and him

refer to both genders.

Spouse

means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship for 12 consecutive months.

Enrolment

To enrol for an amount of Optional Life Insurance that exceeds 3 units of insurance, you must submit a completed enrolment form and evidence of insurability to Sun Life.

To enrol for Optional Dependant Life Insurance you must submit a completed enrolment form for your spouse and dependent children to Sun Life.

To enrol for all other coverage you must submit a completed enrolment form. If you have a dependant, request dependant coverage when you enrol.

If you enrol more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for all amounts of Optional Life Insurance and Extended Health to Sun Life.

If you request Spouse Optional Life Insurance, you must submit evidence of insurability to Sun Life. If you request Optional Child Life Insurance more than 60 days of acquiring a child, you are considered a late entrant and must submit evidence of insurability to Sun Life. If you request all other dependant coverage more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for Extended Health for each dependant to Sun Life.

If you have no dependant when you enrol and later acquire one, request dependant insurance, (eg. birth of first child, marriage).

If your new dependant is a common-law spouse, see your Plan Administrator to find out how to enrol for dependant coverage.

For late entrants, evidence of insurability submitted to Sun Life is at your expense

Effective Date

Your Optional Life Insurance is effective on the later of the date that you become eligible or the date that Sun Life approves the evidence of insurability.

You become eligible for all other coverage on the date you become eligible, unless you are not actively working on that day.

If you are not actively working on the date the insurance would be effective, you become a member on the date you have been actively at work for the preceding 7 consecutive scheduled working days.

Your dependant coverage is effective on the latest of

1. the date that you become eligible for dependant coverage,
2. the date that you request dependant coverage, or
3. the date that Sun Life determines the insurability of all of your dependants, and approves at least one dependant.

If you are absent from work on the date your insurance or your dependant coverage would be effective, then that coverage will not be effective until the date you return to active work.

Changes in Coverage

An increase in your benefits, the amount of your coverage or the amount of your dependant coverage due to change in your group benefit plan's design or a change in your classification becomes effective on the date of the change, unless you are not actively working on that day due to disease or injury.

If you request Optional Life Insurance within 31 days of acquiring a spouse or dependent child, you may elect **3** units of insurance without submitting evidence of insurability to Sun Life. If you request an increase in the amount of Optional Life Insurance more than 31 days after the date of acquiring a spouse or a dependent child you must submit evidence of insurability to Sun Life.

If you request Optional Child Life Insurance more than 60 days of acquiring a dependent child, you must submit evidence of insurability to Sun Life. If you request an increase in the amount of Optional Dependant Life Insurance you must submit evidence of insurability for your spouse and dependent children to Sun Life. The increase in the amount of insurance will be effective on the date that Sun Life approves the evidence of insurability.

If Sun Life doesn't approve an increase in the amount of your coverage or the amount of your dependant coverage, any future increase in the maximum benefit amount will not be effective unless evidence of insurability is approved. An increase in the maximum benefit amount will be effective on the date Sun Life approves the evidence of insurability.

If, due to disease or injury, you are not actively working on the date an increase in your benefits, the amount of your coverage or the amount of your dependant coverage would be effective, the increase becomes effective on the date you return to active work. Sun Life may require evidence of insurability to establish the date that you are physically and mentally fit to return to active work. If so, the increase becomes effective on the date Sun Life establishes. If Sun Life doesn't approve the evidence of insurability required, the increase will not be effective.

Comparable Coverage

If you are covered for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you may request the similar coverage offered under this plan.

If your dependant is covered for comparable coverage under another plan, you may decline the dependant coverage for the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops, you may request the similar coverage offered under this plan.

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

If you request the coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability to Sun Life. If you request the dependant coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life. The coverage that replaces the comparable coverage is effective on the date that Sun Life approves the evidence of insurability. If Sun Life does not approve evidence of insurability required, the coverage will not be effective.

Termination of Coverage

Your coverage could terminate for a number of reasons. For example,

- you are no longer eligible, (i.e. you are no longer actively working),
- you reach the Termination Age,
- the provision or the plan terminates.

Section 1. Insured Provisions

Summary of Insurance

Policy Number *101180*

Life Insurance (Class 3)

Class of Members	Benefit Formula
All Employees	
• Option 1	$5,000
• Option 2	2 times annual earnings rounded to the next higher $500 The maximum benefit is $3,000,000*

*Maximum combined with Optional Life Insurance

Termination of Insurance: 65th birthday, or retirement if earlier

Optional Life Insurance (Class 3)

Class of Members	Benefit Formula
All Employees	As elected by the member, units of $10,000 The maximum benefit is $500,000*

*****Maximum combined with Basic Life Insurance

Evidence of Insurability: required on all amounts of Optional Life Insurance, except for the first $30,000 if the request is made within 31 days of the eligibility date or acquiring a spouse or child.

Termination of Insurance: 65th birthday, or retirement if earlier

Spouse Optional Life Insurance (Class 3)

Amount: as elected by the member, units of $10,000. The maximum benefit is $500,000.

Evidence of Insurability: required on all amounts of Optional Life Insurance

Termination of Insurance: member's 65th birthday, spouse's 65th birthday or member's retirement, whichever is earlier

Child Optional Life Insurance (Class 3)

Each Child: $10,000

Termination of Insurance: member's 65th birthday, or retirement if earlier

Evidence of Insurability: required on all amounts of Optional Life Insurance, except if the request for insurance is made within 60 days of the eligibility date.

Evidence of Insurability: required on all amounts of Optional Life Insurance, except if the request for insurance is made within 60 days of the eligibility date.

A dependent child means an unmarried natural, adopted, or step-child (including children for whom you or your spouse have been appointed the legal guardian) who is entirely dependent on you for maintenance and support and who is

1. under 21 years of age,
2. under 25 years of age and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

Long Term Disability Insurance (Class 3)

Class of Members	Maximum Amount
All Employees	
• With continuous service of at least 6 months but less than 20 years	The maximum amount is 65%* of monthly basic earnings up to a maximum benefit of $50,000. The minimum benefit is $50.
• With continuous service of at least 20 years but less than 30 years	The maximum amount is 70%* of monthly basic earnings up to a maximum benefit of $50,000. The minimum benefit is $50.
• With continuous service of 30 years or more	The maximum amount is 75%* of monthly basic earnings up to a maximum benefit of $50,000. The minimum benefit is $50.

*The percentage of benefit is based on the length of continuous service up to the first day of absence

Monthly Disability Benefit

All references to income below and in the Long Term Disability Insurance Provision are to the gross amounts before any deductions.

Here is how Sun Life calculates your Long Term Disability payments.

Step 1: Sun Life takes the maximum amount specified above.

Step 2: Sun Life subtracts any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependant benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition**
- under the Québec Parental Insurance Plan.

The result from Step 2 is the amount you will normally receive. If this amount plus the above sources of income and all the additional sources of income listed below exceeds 100% of your pre-disability basic earnings, Sun Life will reduce your Long Term Disability payment by the excess.

**If you choose to apply for, and are approved for, the HOOPP disability pension benefit, you can elect to take either the disability pension benefit (immediate, unreduced pension based on your contributory service) or free accrual (you continue to build contributory service under the plan while off work due to disability or disability pension). If you decide to take the free accrual, there will be no change to your monthly Long Term Disability payments. If you decide to take the disability pension benefit, Sun Life will subtract the amount of disability pension you are receiving from your monthly Long Term Disability payments.

If you are eligible for any of the income amounts above and do not apply for them, Sun Life will still consider them part of your income. Sun Life can estimate those benefits and use those amounts when Sun Life calculates your payments. This does not apply to the HOOPP Disability pension benefit. If you choose not to apply for the HOOPP Disability pension benefit, you will not be penalized and no estimated offset will be applied to your payments.

If you receive any of the income amounts above in a lump sum, Sun Life will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.

Sun Life will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

Sun Life has the right to adjust your benefit payments when necessary.

Qualifying Period

Your Long Term Disability payments begin after you have been totally disabled for an uninterrupted period of 30 weeks or after the last day benefits are payable under any short term disability, loss of income or other salary continuation plan, whichever is later.

This period, which must be completed before disability benefits become payable, is the **Qualifying period**.

If you become totally disabled during a lay-off or approved leave and your insurance continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 30 weeks and still be totally disabled on the date you are scheduled to return to full-time work with your employer.

Maximum Benefit Period

Your Long Term Disability payments end on the earlier of the following dates:

- **if the qualifying period ends on or before your 64th birthday: -** your 65th birthday,
- **if the qualifying period ends after your 64th birthday, but before your 65th birthday:** 12 months after the qualifying period ends.
- **if you become totally disabled and continue to be totally disabled after completing 10 years of continuous service :-** the date you die.

Termination of Insurance: your 65th birthday less the qualifying period of 30 weeks or the day you retire, whichever is earlier

Life Insurance Provision

Benefit

If you die while insured, Sun Life will pay the full amount of your benefit to your last named beneficiary. You appoint the beneficiary when enrolling for insurance. The beneficiary designation may be changed, if permitted by law. You must submit written notice of the change. If you have not named a beneficiary, the benefit amount will be paid to your estate.

If a dependant dies, Sun Life will pay you the benefit for that dependent.

However, for your Spouse Optional Life Insurance, Sun Life will pay the full amount of the benefit to the last named beneficiary. You appoint the beneficiary when enrolling for insurance. The beneficiary designation may be changed, if permitted by law. You must submit written notice of the change. If you have not named a beneficiary, the benefit amount will be paid to you.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

For your Optional Life Insurance and your Spouse Optional Life Insurance, Sun Life will not pay benefits for any optional insurance that has been in effect for less than 2 years if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, Sun Life will refund all applicable Life Insurance premiums that have been paid.

Disability Benefit

If you become totally disabled before you retire or reach age 65, whichever is earlier, Optional Life Insurance may continue without the payment of premiums as long as you are totally disabled. This continued insurance is subject to the terms of the policy which were in effect on the date you became totally disabled, including reductions and terminations.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life Insurance, the group Life Insurance will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for:

- an uninterrupted period of 6 months, if not insured under a group Long Term Disability Insurance Provision issued by us or
- the qualifying period for Long Term Disability described in the Summary of Insurance, if you are entitled to Long Term Disability payments.

Optional insurance will continue without payment of premiums, following the qualifying period, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

The Life Insurance for your dependants will also continue without payment of premiums, as long as your Optional Life Insurance is continued without payment of premiums, but not after the Dependant Life Insurance Provision is terminated.

For the purposes of your Optional Life Insurance, you will be considered totally disabled if you are prevented by injury or illness from performing any occupation you are or may become reasonably qualified for by education, training or experience. However, if you are totally disabled under the Long Term Disability Insurance Provision, you are also considered to be totally disabled under the Optional Life Insurance Provision.

Claims

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, Sun Life can require ongoing proof that you are still totally disabled.

From time to time, Sun Life can require that you provide proof of your total disability. If you do not provide this information to Sun Life within 90 days of the request, you will not be entitled to benefits.

Sun Life can require you to have a medical examination if you make a claim for benefits. Sun Life will pay for the cost of the examination. If you fail or refuse to have this examination, Sun Life will not pay any benefit.

Claims for Life benefits must be made as soon as reasonably possible.

Claim forms are available from your employer.

Limitation period for Ontario:

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

Limitation period for any other province:

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

Conversion

If your Life Insurance ends or reduces for any reason other than your request, you may apply to convert the group Life Insurance to an individual Life policy with Sun Life without providing evidence of insurability.

If your spouse's Life Insurance ends for any reason other than your request, your spouse may apply to convert the group Life Insurance to an individual Life policy with Sun Life without providing evidence of insurability.

Where necessary in order to comply with applicable legislation: If your child's Life Insurance ends due to the termination of your Life Insurance, you may apply to convert the group Life Insurance for your child to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days of the reduction or end of the Life Insurance.

There are a number of rules and conditions in the group policy that apply to converting this insurance, including the maximum amount that can be converted. Please contact your employer for details.

Early Payment (Class 3)

Subject to the approval of Sun Life, you may elect early payment of the death benefit equal to 90% of the amount of Life Insurance applicable to you in accordance with the Summary of Insurance, subject to the following conditions:

1. a physician appointed by Sun Life determines that you are apparently certain to die within 12 months of the date of such determination;

2. you are competent to act;

3. you are under age 64 at the time you make the election.

The early payment is in exchange for all other benefits under the Life Insurance provisions.

The participating employer is responsible for the premium payments for you if you have received an advance payment, unless a Waiver of Premium has been granted.

Value of the Early Payment means the aggregate of the payments made under the early payment.

Early Payment Exclusion (Class 3)

The early payment will not be payable if there has been any material misrepresentation or non- disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the early payment is paid, the value of the early payment will be repaid to Sun Life by the recipient of the early payment.

Long Term Disability Insurance Provision

Definitions

Appropriate treatment

means 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 earnings

on a given date, means the rate of the regular remuneration received by you on that date for your regular employment. Earnings for a member with less than one year of service will be the estimated amount of regular remuneration specified by your employer.

Doctor

means a physician or surgeon who is licensed to practice medicine where that practice is located.

Illness

means a bodily injury, disease, mental infirmity or sickness. Any surgery, needed to donate a body part to another person, which causes total disability, is an illness.

Total disability and totally disabled

For your Long Term Disability insurance,

- during the first 2 years (this period is known as the **own occupation period)**, you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

other than in a Sun Life approved partial disability or rehabilitation program.

General Description of the Insurance

Long Term Disability insurance provides a benefit to you if you are totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while insured,
- your total disability has continued beyond the qualifying period specified in the Summary of Insurance, and
- you have been following appropriate treatment for the disability since its onset.

Benefits are paid at the end of each month and are based on your insurance on the date you became totally disabled.

If you are totally disabled for part of any month, Sun Life will pay 1/30 of the monthly benefit for each day you are totally disabled.

Maternity / Parental Leave of Absence

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 30 weeks, provided your insurance has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

Rehabilitation Program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

It may include the involvement of a Sun Life rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for a member. Sun Life will consider such factors as financial considerations and Sun Life's opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long Term Disability payments plus income from other sources. However, the Long Term Disability payments will be reduced by 50% of the income you receive under the rehabilitation program. If during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long Term Disability payments will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled. If you enter a rehabilitation program during the qualifying period, it will not be considered an interruption of the qualifying period.

Interrupted Periods of Disability During the Qualifying Period

Interrupted periods of total disability due to the same or related causes occurring before the qualifying period has been completed are treated as one period of disability and are accumulated to complete the qualifying period as long as this benefit is in force and all of the following conditions are met:

- there is no interruption of more than 3 weeks.
- each period of total disability is completed within 12 months after the start of the qualifying period, or as approved by Sun Life in advance in cases where the qualifying period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the qualifying period.

If the Long Term Disability benefit terminates, any balance of the qualifying period must subsequently be completed by uninterrupted total disability.

Interrupted Periods of Disability After Payments Begin

If you had a total disability for which Sun Life paid Long Term Disability benefits and total disability occurs again due to the same or related causes, Sun Life will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability. You must be insured when total disability reoccurs.

These benefits will be based on your insurance as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum benefit period.

Your Responsibilities

During your total disability, you must make reasonable efforts to:

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
- return to your own occupation during the first 2 years of total disability.
- 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 2 years of total disability.
- try to obtain work in another occupation after the first 2 years of total disability.
- obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

Payments after Insurance Ends

If the Long Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

Exclusions and Limitations

Sun Life will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under Maternity / Parental Leave of Absence or except where specifically agreed to by Sun Life.

Sun Life 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.
- intentionally self-inflicted injuries.
- participation in a criminal offence excluding operating a vehicle while your blood contains more than 80 milligrams of alcohol per 100 millimetres of blood.

Claims

To make a claim, complete the Notice of Claim for Group Long Term Disability Benefits that is available from your employer.

Sun Life must receive notice of claim on the earlier of the following dates:

- 10 weeks after the total disability begins.
- within 30 days of the termination of this Long Term Disability benefit.

Part of the application process will include filling out claim forms that give Sun Life as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, Sun Life must receive these forms no later than 15 weeks after the end of the qualifying period.

Sun Life will assess the claim and send you or your employer a letter outlining Sun Life's decision.

From time to time, Sun Life can require that you provide with proof of your total disability. If you do not provide this information to Sun Life within 90 days of this request, you will not be entitled to benefits.

Sun Life can require you to have a medical examination if you make a claim for benefits. Sun Life will pay for the cost of the examination. If you fail or refuse to have this examination, Sun Life will not pay any benefit.

In the case your claim is declined or benefit payments are terminated, you can appeal that decision by submitting new medical evidence within 3 months of the date of Sun Life's letter advising you of the decision.

If, after you have followed this appeal process for declined claims and Sun Life is satisfied that all available medical documentation has been submitted but the decision has not changed, you will be offered MAP (Medical Appeals Process) for final resolution of the claim.

First, you will be asked to sign an agreement and authorization form to continue with the appeal process. Then you will appoint a physician to act on your behalf. Sun Life's Medical Director or designate will act on Sun Life's behalf. The two physicians will jointly choose a third independent physician to review all available medical and functional evidence and undertake additional tests or examinations, as deemed necessary.

The decision of the independent physician to admit the claim or to maintain the decline is binding on you and Sun Life, and no further action can be taken. If the decision is to admit your claim, Sun Life still has the right to periodic reviews of your condition to determine continuation of benefits.

Limitation period for Ontario:

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

Limitation period for any other province:

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

Section 2. Administered Services for Non-Insured Benefits

Summary of Benefits

Plan Number *78180*

Extended Health (Classes 3 and 12)

Part	Benefit	Deductible		Reimbursement
		per person	per family unit	
A	Drug: Pay Direct	None	None	100%
B	Vision: $300**	None	None	100%
C	Hospital: ward to semi-private	None	None	100%
D	Supp. Health Care: includes private room accommodation	$22.50*	$35*	100%
E	Out-of-Province Emergency	None	None	100%

*The deductible applies per calendar year. The deductible applies to the eligible expenses of Part D.

**Maximum for eyeglasses/contact lenses and laser eye surgery every 24 month period for you and for each covered dependant.

Other maximums are listed under the appropriate Provision page.

Termination Age:
Class 3: member's 70th birthday, or retirement if earlier
Class 12: member's 65th birthday

Dental (Classes 3 and 12)

Part	Benefit	Deductible per person	Deductible per family unit	Reimbursement	Maximum
A	Basic	None	None	100%	--
B	Denture	None	None	50%	$1,000*
D	Endodontic and Periodontic	None	None	100%	--
E	Denture Repair	None	None	100%	--
F	Crown and Bridge	None	None	50%	$1,000**
G	Surgical Removal	None	None	100%	--
H	Surgical Services and Drug	None	None	100%	--

*The maximum amount payable applies to the eligible expenses incurred in a calendar year under Part B for you and for each covered dependant.

**The maximum amount payable applies to the eligible expenses incurred in a calendar year under Part F for you and for each covered dependant.

Late Entrant Maximum: If you or your eligible dependant becomes covered more than 31 days after the date you became eligible for the Dental Provision, the maximum amount payable for the combined eligible expenses of all parts incurred during the first 12 months of coverage will be limited to $250 for you and for each covered dependant.

Termination Age:
Class 3: member's 70th birthday, or retirement if earlier
Class 12: member's 65th birthday

Dental Fee Guide: The applicable fee guide is the one in force for general practitioners on the day when and in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide plus an inflationary adjustment determined by Sun Life.

Extended Health Provision

Benefit

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. To determine the amount payable, the total amount of eligible expenses you claim will be adjusted as follows:

1. the deductible, which is an amount that you must pay each calendar year, is subtracted,
2. the reimbursement percentage, which is the percentage of the eligible expense submitted that Sun Life will pay is applied, and
3. the maximum is applied.

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

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

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

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

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

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

Claims for you and your spouse should be submitted in the following order:

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

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

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

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

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

When you submit a claim, you have an obligation to disclose to Sun Life all other equivalent coverage that you or your dependants have.

Claims

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

For the assessment of a claim, itemized bills, attending physician statements or other necessary information are required.

If your physician is recommending medical treatment that is expected to cost more than $1,000, you should request pre-authorization to ensure that the expenses are covered.

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

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,

- expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with Government Programs*,
- expenses for benefits which are legally prohibited by the government from coverage,
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

Integration with Government Programs

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

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

- whether you or your dependant have made an application to the government program,
- whether coverage under this plan affects your or your dependant's eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

My Health CHOICE Coverage

If your coverage under this plan terminates because your employment has ended, you may purchase Sun Life's My Health CHOICE coverage. This coverage is different from your group plan.

To be eligible for My Health CHOICE coverage, you must:

- apply for My Health CHOICE coverage within 60 days after the termination of your coverage,
- be under age 75 on the date you apply, and
- be a resident of Canada and be covered under the provincial health plan.

My Health CHOICE coverage may also include Dental coverage if you were covered for both Extended Health Care and Dental Care benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependents if those family members were covered under your group plan. Your spouse must be under age 75 on the date you apply for this coverage.

From time to time, Sun Life may review the eligibility requirements and, on the date you apply for My Health CHOICE coverage, they may be different from those listed in this booklet.

To apply for My Health CHOICE or if you have any questions, please call our Customer Solutions Centre at 1-877-893-9893.

Extended Health – Pay Direct Drug Benefit

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*. There are additional eligibility requirements that apply, see *Prior authorization program* for details.

1. drugs, including over-the-counter drugs.
2. injectible drugs.
3. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
4. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.

Drug evaluation

The following drugs will be evaluated and must be approved by Sun Life to be eligible for coverage:

1. drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
2. drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of Sun Life's approval.

Sun Life will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar condition(s).
- plan sustainability.

Drug Substitution Limit

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

Prior Authorization Program

The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If the covered person submits a claim for a drug included in the PA program and has not been pre-approved, the claim will be declined.

In order for drugs in the PA program to be covered, the covered person needs to provide medical information using Sun Life's PA form. Both the covered person and the attending physician need to complete parts of the form.

The covered person will be eligible for coverage for these drugs if the information provided by the covered person and the attending physician meets Sun Life's clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- the covered person's response to preferred drug therapy.

If not, the claim will be declined.

The prior authorization forms are available from the following sources:

1. Sun Life's website at www.mysunlife.ca/priorauthorization
2. Sun Life's Customer Care centre by calling toll-free 1-800-361-6212

Other Health Professionals Allowed to Prescribe Drugs

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

Exclusions

No benefit is payable for

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

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

Extended Health – Vision Benefit

Definitions

Laser Eye Surgery

means the expenses incurred for laser eye surgery performed by an ophthalmologist licensed to practice ophthalmology, limited to the maximums and reimbursement percentage specified in the Summary of Benefits for the vision care benefit. You, or your covered dependant who has received reimbursement for laser eye surgery, will not be eligible for eyeglasses and contact lenses expenses during the same vision benefit period following the surgery.

Ophthalmologist

means a person licensed to practise ophthalmology.

Optometrist

means a member of the Canadian Association of Optometrists or of a provincial association associated with it.

Reasonable and customary charges

mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

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

1. eye examinations by an ophthalmologist or optometrist limited to one examination in a 24 month period for you and for each covered dependant.
2. laser eye surgery and eyeglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Benefits for eligible expenses incurred during a 24 month period for you and for each covered dependant.

Exclusions

No benefit is payable for

1. non-prescription sunglasses,
2. safety glasses,
3. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Hospital Benefit

Definitions

Chronic Hospital

means a legally licensed hospital with beds or units designated for chronic care and which provides facilities for diagnosis, care and treatment of a person suffering from disease or injury on a 24 hour basis, with 24 hour services by registered nurses and physicians. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges

mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for

1. accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.
2. room and board charges for ward accommodation for chronic care (not custodial care) provided in a licensed hospital. Confinement must be certified as medically necessary by a physician and is limited to $3 per day and 120 days in a calendar year.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Supplementary Health Care Benefit

Definitions

Chiropodist, Podiatrist

means a person licensed by the appropriate provincial licensing authority.

Chiropractor

means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Naturopath

means a member of the Canadian Naturopathic Association or any provincial association affiliated with it.

Osteopath

means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association or a person who holds a Diploma in Osteopathic Manual Practice (DOMP).

Physiotherapist

means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.

Psychologist

means a permanently certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.

Reasonable and customary charges

mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Massage Therapist

means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications Sun Life determines to be comparable with those required by a licensing body.

Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant, Licensed Practical Nurse, Registered Practical Nurse

means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Speech Language Pathologist

means a person who holds a master's degree in Speech Language Pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it.

Eligible Expenses

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

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

1. the services of a registered nurse (R.N.), registered nursing assistant (R.N.A.), certified nursing assistant (C.N.A.), licensed practical nurse (L.P.N.) or a registered practical nurse (R.P.N.) when provided in the patient's home, limited to $5,000 in a calendar year, less the amount paid in the previous 2 years, and $50 per day thereafter. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A., L.P.N. or a R.P.N.
2. the services of a physiotherapist, limited to a calendar year maximum of $350*.
   *Effective September 29, 2015, the calendar year maximum increases to $375.
3. the services of a registered massage therapist, limited to $7 per visit and a maximum of 12 visits a calendar year. Physician or nurse practitioner's prescription required.
4. the services of a speech language therapist, as prescribed by a physician, limited to a maximum of $200 in a calendar year.
5. the services of a registered clinical psychologist, limited to $35 for the initial visit and $20 per hour for each subsequent visit, limited to a maximum of $200 in a calendar year.
6. services of a chiropractor, limited to $375 in a calendar year. Xrays are limited to $25 in a calendar year. Physician's prescription not required.
7. services of a naturopath, limited to $7 per visit and 20 visits in a calendar year. Physician's prescription not required.
8. services of an osteopath, limited to $7 per visit and 20 visits in a calendar year. Physician's prescription not required.
9. services of a chiropodist or podiatrist, limited to $7 per visit and 20 visits in a calendar year. Physician's prescription not required.
10. the services of a dentist or dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are started within 90 days of the accident and completed within one year of such date. Charges incurred for or in connection with surgery and related medical care for treatment of a disease, other than periodontal disease; injury to the jaw or facial bone, removal of cysts, leukoplakia or malignant tissue, correction of harelip, cleft palate or protruding mandible or freeing of muscle attachments will also be payable under this benefit.

11. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
12. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient required the services of a registered nurse during the flight, the services and return air fare for a registered nurse.
13. custom made orthopaedic shoes, orthopaedic modifications to shoes, and custom made orthotics, when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist or chiropractor. Orthotics are limited to $400 per pair and 2 pair per calendar year.
14. hearing aids and repairs to them, excluding replacement batteries, limited to an acquisition every 36 months.
15. trusses and crutches.
16. braces, provided they are not solely for athletic use.
17. artificial limbs or other prosthetic appliances, including repairs.
18. corrective prosthetic lenses and frames, following cataract surgery or when missing organic lenses, limited to 1 pair per lifetime.
19. oxygen, blood and blood products.
20. urinary kits.
21. surgical dressings.
22. surgical stockings, limited to 6 pair per calendar year.
23. wigs required as a result of chemotherapy or radiation treatment, limited to 1 per lifetime.
24. surgical brassieres, limited to 6 per calendar year.
25. diagnostic laboratory and x-ray examinations.
26. outpatient services.
27. rental, or purchase at Sun Life's option, of durable equipment which is required for temporary therapeutic use in the patient's home and is approved by Sun Life. Eligible durable equipment includes, but is not limited to, items such as:
    - wheel chairs,
    - wheel chair repairs,
    - walkers,
    - hospital beds,
    - traction kits
    - respirators.
28. private accommodation in a hospital, limited to the difference between the charges for semi-private accommodation and private accommodation for each day of hospitalization.
29. room and board and normal nursing care in a private hospital, when certified as medically necessary, limited to $10 per day to a maximum of 120 days in a calendar year.

Exclusions and Limitations

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the use of services,
5. nebulizers and vaporizers,
6. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

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

Extended Health – Out-of-Province Emergency and Travel Assistance Benefit

To be covered for this benefit, you and your covered dependant must have provincial health care coverage. Expenses for hospital/medical services are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside your home province,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 60 days of travelling on vacation or business outside your home province. Your 60 days of coverage starts on the day you or your covered dependant departs from your home province.

Definitions

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

Emergency services
mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your covered dependant has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Family member
means you or your covered dependant.

Reasonable and customary charges
mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (Allianz Global Assistance). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then we have the right to deny or limit payments for all expenses related to that emergency.

Neither we nor Allianz Global Assistance is responsible for the availability, quality or results of the medical treatment received by the family member, or for the failure to obtain medical treatment.

An emergency ends when the family member is medically stable to return to his province of residence.

Emergency Services Excluded from Coverage

Any expenses related to the following emergency services are not covered:

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that we or Allianz Global Assistance, based on available medical evidence, determines that the family member can be returned to his province of residence, and he refuses to return.
4. services which are required for the same illness or injury for which the family member received emergency services, including any complications arising out of that illness or injury, if the family member had unreasonably refused or neglected to receive the recommended medical services.
5. where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Eligible Expenses for Hospital/Medical Services

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

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

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

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

Claims for Eligible Hospital/Medical Services

1. pay for the expense as soon as it is incurred,
2. submit your claim to the provincial health care plan for consideration,
3. submit any unpaid amounts of your claim to Sun Life.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your covered dependant due to an emergency which occurs more than 60 days after departure from your province of residence,
2. expenses incurred on a non-emergency or referral basis,
3. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Provision.

If you are covered as a retired employee, you and your covered dependants must return to your province of residence for at least 30 consecutive days before you become eligible for another 60 days of coverage.

Dental Provision

Benefit

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the deductible, which must be satisfied each calendar year, is subtracted,
2. the reimbursement percentage is applied, and
3. the maximums specified in the Summary of Benefits are applied.

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

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

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

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

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

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

Claims for you and your spouse should be submitted in the following order:

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

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

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

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

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

When you submit a claim, you have an obligation to disclose to Sun Life all other equivalent coverage that you or your dependants have.

Claims

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

For the assessment of a claim, itemized bills, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other necessary information may be required.

If your dentist has recommended dental treatment that is expected to cost more than $500, you must have your dentist prepare a pre-treatment plan.

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

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for which benefits are payable under a government plan,
- expenses for correction to temporomandibular joint dysfunction.

Dental Provision – Basic Benefit

Eligible Expenses

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

a. examination and diagnosis
   - oral examination (once every 3 years),
   - recall oral examination (once every 9 months)
   - special oral examination,
   - treatment planning,
   - consultation (maximum 2 units every 12 months),
   - house call, institutional call and office visit

b. tests and laboratory examinations
   - microbiological test,
   - caries susceptibility test,
   - biopsy of oral tissue,
   - cytologic smear from oral cavity,
   - pulp vitality tests,

c. radiographs
   - complete series (once every 3 years),
   - periapical, 1 to 15 films
   - occlusal,
   - bitewing (once every 9 months)
   - extraoral,
   - sialography,
   - radiopaque dyes to demonstrate lesions,
   - temporomandibular joint,
   - panoramic (once every 3 years),
   - cephalometric film,
   - interpretation of radiographs received from another source,
   - tomography,
   - hand and wrist (as diagnostic aid for dental treatment)

d. preventive services
    - dental polishing (one unit of time once every 9 months)
    - topical application of fluoride,
    - oral hygiene instruction (once every 9 months)
    - caries control,
    - interproximal discing of teeth,
    - recontouring to teeth for functional reasons
    - occlusal adjustment/equilibration (8 units of time every 12 months)
e. restorations
    - amalgam,
    - retentive pins,
    - acrylic or composite resin,
    - prefabricated restorations
f. anaesthesia
g. laboratory procedures

Dental Provision – Denture Benefit

Eligible Expenses

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

a. partial and complete dentures
   - complete dentures (once every 3 years),
   - partial dentures (once every 3 years),
   - remake dentures

b. laboratory procedures

Dental Provision – Endodontic and Periodontic Benefit

Eligible Expenses

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

a. periodontics
   - non surgical services,
   - surgical services,
   - post-surgical treatment,
   - scaling and root planing,
   - adjunctive procedures,
   - alveoloplasty
   - vestibuloplasty

b. endodontics
   - pulpotomy,
   - root canal therapy,
   - periapical services,
   - other endodontic procedures,
   - emergency procedures

c. laboratory procedures

Dental Provision – Denture Repair Benefit

Eligible Expenses

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

a. repairs and adjustments
   - adjustment to dentures,
   - repairs/additions to dentures,
   - denture rebasing and relining
   - resetting of teeth

b. laboratory procedures

Dental Provision – Crown and Bridge Benefit

Eligible Expenses

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

a. crowns, inlays, onlays
   - gold foil restorations,
   - inlay restorations,
   - onlay restorations,
   - crowns,
   - other restorative services

b. fixed bridgework
   - bridge pontics,
   - repairs to bridges,
   - retainers,
   - other prosthetic services

c. laboratory procedures

Replacement of an existing denture or bridgework is an eligible expense if the replacement is required to replace an existing denture or bridgework which was installed at least 3 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

Dental Provision – Surgical Removal Benefit

Eligible Expenses

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

a. surgical services
   - uncomplicated removals,
   - surgical removals

b. laboratory procedures

Dental Provision – Surgical Services and Drug Benefit

Eligible Expenses

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

a. surgical services
   - surgical exposure, transplantation and repositioning,
   - surgical excision,
   - surgical incision,
   - fractures,
   - frenectomy,
   - miscellaneous surgical services

b. adjunctive general services
   - drugs (injections)

c. laboratory procedures

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