



your **group**  
benefits

**Trent University**

**Part-time Academic Employees**

**Contract Number 50490**  
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## General Information

### About this booklet

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

Your group benefits may be modified after the effective date of this booklet. You will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet.

If you have any questions about the information in this employee benefits booklet, or you need additional information about your group benefits, please contact your employer.

### Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a part-time academic staff member.
- you are a member of the bargaining unit represented by the Canadian Union Of Public Employees (or successor organization or equivalent) who is not covered by another plan and who has continuous employment at Trent University for more than three months during the academic year.
- you have completed the waiting period.

The waiting period for your group plan ends on the last day of the month in which your employment began.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3

**Who qualifies as your dependent**

months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Your dependent must be your spouse or your child and a resident of Canada or the United States.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last year, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, we will continue coverage as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

In these cases, you must notify Sun Life within 31 days of the date the child attains the limiting age. Your employer can give you more information about this.

**Enrolment**

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request dependent coverage.

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

Normally, you request coverage for yourself or your dependents within 31 days of becoming eligible for coverage. If you do not request coverage within this time limit, you will have to provide proof of good health at your own expense.

**When coverage begins**

Your coverage begins on the later of the following dates:

- the date you become eligible for coverage.
- the date your employer receives your enrolment information for coverage.
- the date Sun Life approves your proof of good health, if required.

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

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

- the date your coverage begins.
- the date the dependent becomes eligible for coverage.
- the date Sun Life approves the dependent's proof of good health, if required.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

Once you have dependent coverage, any subsequent dependents will be

covered automatically.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

**Changes affecting your coverage**

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exceptions apply if the result of the change is an increase in coverage:

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

**Updating your records**

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- change of dependents.
- change of name.

**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 contract.

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](http://www.mysunlife.ca).
- our Customer Care centre by calling toll-free at 1-800-361-6212.

**When coverage ends** As an employee, your coverage will end on the earlier of the following dates:

- the last day of the month in which your employment ends or you retire.
- the last day of the month in which you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

A dependent's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage may vary from benefit to benefit. For

information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

However, if you die while covered by this plan, coverage for your dependents will continue until the earlier of the following dates:

- the date the person would no longer be considered your dependent if you were still alive.
- the last day of the third month following the month in which you die.
- the end of the period for which premiums have been paid for dependent coverage.
- the date the benefit provision under which the dependent is covered terminates.

**Replacement coverage**

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

**Making claims**

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life or electronically if indicated in the appropriate section of this booklet.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

**Legal actions**

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

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

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim.

**Coordination of benefits**

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, our benefits will be coordinated 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 coordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a coordination of benefits clause.

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

The maximum amount that you can receive from all plans for eligible

expenses is 100% of actual expenses.

Where both plans contain a coordination 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:***

- 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.
- the plan where the person is covered as a dependent.

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

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- 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 child, in which case the following order applies:

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.
- the plan of the parent not having custody of the child.
- the plan of the spouse of the parent not having custody of the child.

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

Your employer can help you determine which plan you should claim from first.

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

**Recovering overpayments** We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

**Definitions** Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.

***Accident*** An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.

***Doctor*** A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

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

***Retirement date*** If you are totally disabled, your retirement date is the last day of the month in which you reach age 65, unless you have actually retired before then.

***We, our and us*** We, our and us mean Sun Life Assurance Company of Canada.

## Semi-Private Hospital Care

**General description of the coverage** In this section, *you* means the employee and all dependents covered for Semi-Private Hospital Care benefit

Semi-Private Hospital Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

**Deductible** There is no deductible for this coverage.

**Hospital expenses in and out of Canada** We will cover 100% of the costs for hospital care in and out of Canada.

We will cover the difference between the cost of a ward and a semi-private hospital room.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

For purposes of this plan, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

***Chronic care hospital*** We will cover 100% of the cost of room and board in a chronic care hospital.

The maximum amount payable is the difference between the cost of a ward and a semi-private room. The maximum amount payable is \$3 per day, up to a maximum of 120 days per person per benefit year.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

**When coverage ends** Semi-Private Hospital Care coverage will end on the last day of the month in which the employee retires (except if on an approved voluntary early retirement) or reaches age 65, whichever is earlier.

Coverage may also end on an earlier date, as specified in *General Information*.

**Payments after coverage ends** If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and

- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

**What is not covered** We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made



in the absence of this coverage.

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

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

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

We will also not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer or on our website at [www.mysunlife.ca](http://www.mysunlife.ca).

In order for you to receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your Semi-Private Hospital Care coverage.

## Extended Health Care (Medicare Supplement)

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

**Deductible** The deductible is the portion of claims that you are responsible for paying.

The deductible is \$25 each benefit year for each person up to a maximum of \$50 per family.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

If 2 or more members of your family suffer injuries in the same accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.

**Prescription drugs (Drug card plan)** We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- drugs for the treatment of sexual dysfunction, up to a maximum of \$1,200 per person in a benefit year.
- colostomy supplies.
- varicose vein injections.

We will only pay for quantities that can reasonably be used in a 90 days period.

We will cover 100% of the cost of the above drugs and supplies after you pay the deductible.

We will not pay for the following, even when prescribed:

- over-the-counter drugs except for those that Sun Life determines to be life sustaining.
- infant formulas (milk and milk substitutes), minerals, proteins and collagen treatments.
- the cost of giving injections, serums and vaccines.

- hair growth stimulants.
- vitamins or vitamin preparations, unless injected.
- drugs that are used for cosmetic purposes.
- drugs for the treatment of infertility.
- natural health products, whether or not they have a Natural Product Number (NPN), except as otherwise provided under the list of eligible expenses above.
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

***Drug 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 you and your doctor 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 you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.

In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.

You will be covered for these drugs if the information you and your doctor provide meets our medical criteria. If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

- our website at [www.mysunlife.ca/priorauthorization](http://www.mysunlife.ca/priorauthorization)
- our Customer Care centre by calling toll-free 1-800-361-6212

***Other health professionals allowed to prescribe drugs***

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

**Hospital expenses in your province**

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

We will cover out-patient services in a hospital, after you pay the deductible, except for any services explicitly excluded under this benefit, and the difference between the cost of a semi-private and a private hospital room.

We will also cover 100% of the costs for private hospital care in the province where you live, after you pay the deductible. The maximum amount payable is \$10 per day up to a maximum of 120 days for treatment of an illness due to the same or related causes.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

**Expenses out of your province**

We will cover emergency services while you are outside the province where you live. We will also cover referred services.

For both emergency services and referred services, we will cover the cost of:

- the difference between a semi-private and a private hospital room.
- other hospital services provided outside of Canada.

- out-patient services in a hospital.
- the services of a doctor.

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you live, subject to the reimbursement level and all conditions applicable to those expenses.

***Emergency services*** We will pay 100% of the cost of covered emergency services after you pay the deductible.

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ 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 Europ Assistance cannot be made before services are provided, contact with Europ 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 Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when you are medically stable to return to the

province where you live.

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Europ Assistance, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and Europ Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Europ Assistance will ask you to sign a form authorizing them to act on your behalf.

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

***Emergency services  
excluded from  
coverage***

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

- services that are not immediately required or which could

reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.

- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

***Referred services*** *Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 100% of the costs of referred services after you pay the deductible. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.



**Medical services and equipment**

We will cover 100% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, up to a maximum of \$25 per person over 2 benefit years.

- corrective prosthetic lenses and frames for persons who lack an organic lens or after cataract surgery, limited to once during a person's lifetime.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches, cervical collars, catheters, urinary kits or ostomy supplies (where a surgical stoma exists).
- external breast prostheses required as a result of surgery.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes. For myoelectric or sport prosthesis, coverage is limited to the amount that would otherwise be paid for standard type artificial limbs.
- custom-made orthotic inserts for shoes, including repairs, when prescribed by a doctor, podiatrist or chiropodist, limited to 1 pair in any 12 month period for a person under age 18 or in any 24 month period for any other person.
- custom-made orthopaedic boots or shoes or modifications to regular footwear.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$300 per person over a period of 5 benefit years. Repairs are included in this maximum. The deductible does not apply to these expenses.
- radiotherapy or coagulotherapy.

**Paramedical services**

- oxygen, plasma and blood transfusions.

We will cover 100% of the costs after you pay the deductible, for each category of paramedical specialists listed below:

- licensed speech therapists, when ordered by a doctor, up to a maximum of \$200 per person in a benefit year.
- licensed psychologists, up to a maximum of \$200 per person in a benefit year.
- licensed massage therapists, when ordered by a doctor, up to a maximum of \$100 per person in a benefit year.
- licensed physiotherapists.

We will cover 100% of the costs without a deductible, up to a maximum of \$300 per person in a benefit year for each category of paramedical specialists listed below:

- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, naturopaths, podiatrists or chiropodists, including a maximum of one x-ray examination per specialty each benefit year.

**Contact lenses or eyeglasses**

We will cover the cost of contact lenses or eyeglasses as long as they are prescribed by an ophthalmologist or licensed optometrist and are obtained from an ophthalmologist, licensed optometrist or optician.

We will cover 100% of these costs up to a maximum of \$250 per person in any 12 month period.

The deductible does not apply to eyeglasses or contact lenses.

We will not pay safety glasses of any kind, unless they are prescription safety glasses needed for the correction of vision.

We will not pay for sunglasses or magnifying glasses of any kind.

**When coverage ends**

Extended Health Care coverage will end on the last day of the month in which the employee retires (except for an employee on an approved

voluntary early retirement) or reaches age 65, whichever is earlier.

Coverage may also end on an earlier date, as specified in *General Information*.

**Payments after coverage ends**

If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

**What is not covered**

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers,

and equipment used to treat seasonal affective disorders).

- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

**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 have made an application to the government program,
- whether coverage under this plan affects your eligibility or entitlement to any benefits under the government program, or

- any waiting lists.

We will also not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.

**When and how to  
make a claim**

To make a claim, complete the claim form that is available from your employer or on our website at [www.mysunlife.ca](http://www.mysunlife.ca).

In order for you to receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses,  
or
- the end of your Extended Health Care coverage.

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## Dental Care

**General description of the coverage**

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

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

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives which was current one year prior to the date of July coincident with or immediately preceding the date the eligible expenses were incurred, regardless of where the treatment is received.

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide approved by the provincial Dental Association for that specialist will be used.

When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

When deciding what we will pay for a procedure, we will first find out if other or 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 that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

The benefit year is from January 1 to December 31.

**Deductible**

There is no deductible for this coverage.

**Predetermination**

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

**Preventive dental procedures**

Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

We will pay 100% of the eligible expenses for these procedures.

***Oral examinations***

1 complete examination every 24 months.

1 recall examination every 5 months, up to a maximum of 2 examinations per benefit year.

Emergency or specific examinations.

***X-rays***

1 complete series of x-rays or 1 panorex every 24 months.

1 set of bitewing x-rays every 5 months, up to a maximum of 2 sets per benefit year.

X-rays to diagnose a symptom or examine progress of a particular course of treatment.

***Other services***

Required consultations between two dentists.



Polishing of teeth and topical fluoride treatment once every 5 months, up to a maximum of 2 per benefit year.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 5 months, up to a maximum of 2 sessions per benefit year.

**Basic dental procedures**

Your dental benefits include the following procedures used to treat basic dental problems.

We will pay 100% of the eligible expenses for these procedures.

*Fillings* Amalgam, composite, acrylic or equivalent.

*Extraction of teeth* Removal of teeth, except removal of impacted teeth (*Preventive dental procedures*).

*Basic restorations* Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.

*Endodontics* Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

*Periodontics* Treatment of disease of the gum and other supporting tissue.

Scaling and root planing.

*Oral surgery* Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).

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<i>Repair</i>	Repair of bridges or dentures.
<i>Rebase or reline</i>	Rebase or reline of an existing partial or complete denture.  Professional visits.
<b>When coverage ends</b>	Dental Care coverage will end on the last day of the month in which the employee retires (except for an employee on an approved voluntary early retirement) or reaches age 65, whichever is earlier.  Coverage may also end on an earlier date, as specified in <i>General Information</i> .
<b>Payments after coverage ends</b>	If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 12 months after the date of the accident.
<b>What is not covered</b>	We will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.  We will not pay for services or supplies that are not usually provided to treat a dental problem.  We will not pay for: <ul style="list-style-type: none"><li>■ procedures performed primarily to improve appearance.</li><li>■ the replacement of dental appliances that are lost, misplaced or stolen.</li><li>■ charges for appointments that you do not keep.</li><li>■ charges for completing claim forms.</li><li>■ services or supplies for which no charge would have been made in the absence of this coverage.</li><li>■ supplies usually intended for sport or home use, for example, mouthguards.</li></ul>

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- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
  - charges related to implants, including surgery charges.
  - transplants, and repositioning of the jaw.
  - experimental treatments.

We will also not pay for dental work resulting from:

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

We will also not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer or on our website at [www.mysunlife.ca](http://www.mysunlife.ca). The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive a claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your Dental Care coverage.

We can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any additional information that we consider necessary.

## Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. All such persons are required to maintain the security of your personal information in accordance with our Privacy Policy. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at [www.sunlife.ca](http://www.sunlife.ca), or to obtain information about our privacy practices, send a written request by e-mail to [privacyofficer@sunlife.com](mailto:privacyofficer@sunlife.com), or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

