Sun Life Financial

your group benefits

Trent University

Non-Academic Employees in Exempt Group

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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 full-time member of the Non Academic Exempt Group as designated by your employer. Any other person designated by the employer in writing to Sun Life.
- you are actively working for your employer at least 17 1/2 hours a week.
- 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. However, for the Life and Long-Term Disability benefits, if your employment began on the first day of the month, there is no waiting period.

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 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.

Who qualifies as your dependent

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.

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health. Proof of good health is waived if your request for an increase in coverage is received within 31 days of the date you acquire a dependent.

When coverage begins

For Optional Employee Life, Semi-Private Hospital Care, Extended Health Care and Dental Care, your coverage begins on the later of the following dates:

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

For all other benefits, your coverage begins on the date you become eligible for coverage.

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

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

- the date your coverage begins.

- the date 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.
- change of beneficiary.

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.
- 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:

Life Coverage and Long-Term Disability

- the date your employment ends for any reason other than retirement on pension.
- the date 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.

All other benefits

- the last day of the month following the month in which your employment ends for any reason other than retirement on pension.
- 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

Limitation period for Ontario:

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

Limitation period for any other province:

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

Proof of disability

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

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.

Appropriate treatment

Appropriate treatment is defined as 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

Salaried Employees who are on an approved voluntary early retirement program or granted a leave of absence – Basic earnings are the gross annual salary or wage you receive from your employer if employed on a full-time basis for a full year, excluding bonuses, commissions, overtime, incentive pay, living allowances, payments for research, stipends, grants-in-aid or additional income for part-time teaching, as determined by your employer.

All other Salaried Employees – Basic earnings are the salary you receive from your employer excluding any bonus, overtime, commissions, incentive pay, living allowances, payments for research, stipends, grants-in-aid, or additional remuneration for part-time teaching, as determined by your employer.

Full-time Hourly Employees– Basic earnings are 2,080 times your normal hourly rate or the contracted number of hours as determined by your employer.

Employees with split appointments – Basic earnings are your contract salary as recorded by your employer.

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 *For Life coverage* – If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

All other benefits – 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

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Trent University.

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 expenses that you incur while covered under this plan.

Eligible expenses mean expenses:

- incurred for the services:
  - medically necessary for the treatment of an illness and
  - meeting other requirements described below.
- not exceeding the reasonable and usual rates in the locality where the service is provided.

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

Reference to doctor may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a doctor. For Prescription drugs, refer to *Other health professionals allowed to prescribe drugs and supplies.*

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.

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 following the month in which the employee retires, reaches age 65 or employment terminates, whichever is earlier.** Coverage may also end on an earlier date, as specified in *General Information*.

**Coverage will be extended beyond this date provided you continue actively working at least 17.5 hours per week.

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.

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)

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Trent University.

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 expenses that you incur while covered under this plan.

Eligible expenses mean expenses:

- incurred for the services, drugs and supplies:
  - medically necessary for the treatment of an illness and
  - meeting other requirements described below.
- not exceeding the reasonable and usual rates in the locality where the service, drug or supply is provided.

Supplies include equipment, devices and other similar items.

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

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

Reference to doctor may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a

doctor. For Prescription drugs, refer to *Other health professionals allowed to prescribe drugs and supplies.*

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

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)

To be eligible under Prescription drugs, drugs and supplies must have a Drug Identification Number (DIN) or Product Identification Number (PIN) and, when applicable, be approved under *Evaluation of drugs and supplies*.

Of these eligible drugs and supplies, we will cover the following when prescribed by a doctor or dentist and obtained from a pharmacist:

- 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.
- diabetic supplies. However, if a limit or other eligibility criteria are specified for certain diabetic supplies, either under this list of eligible expenses or under *Medical services and equipment*, then such limit or criteria will apply to those supplies.

- Continuous Glucose Monitoring (CGM) systems and their parts, including both intermittently scanned and real-time monitors, as determined by us, up to a combined maximum of $4,000 per person per benefit year, subject to any clinical criteria that we may require.
- products to help a person quit smoking that legally require a prescription.
- treatments for weight loss, including drugs, proteins and food or dietary supplements. However, certain anti-obesity drugs may be eligible with prior approval (see Prior authorization program for details).
- 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.

Payments for any single purchase are limited to quantities that can reasonably be used in a 90 day period.

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

Other health professionals allowed to prescribe drugs and supplies

If applicable provincial legislation allows:

- other qualified health professionals to prescribe certain drugs or supplies, or
- pharmacists, in providing pharmacy services, to recommend and dispense certain drugs and supplies,

then we will reimburse these drugs and supplies prescribed by other qualified health professionals or recommended and dispensed by a pharmacist, as applicable, the same way we would if a doctor or dentist prescribed them.

Drugs and supplies excluded from coverage

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.

Evaluation of drugs and supplies

The following will be evaluated and must be approved by us to be eligible or to continue to be eligible for coverage:

- drugs when Health Canada issues a new or amended Notice of Compliance on or after November 1, 2017.
- supplies initially made available for sale on the Canadian market on or after March 1, 2026.
- drugs or supplies covered under this plan on March 1, 2026 or subsequently covered, after which, they undergo change(s) or are affected by changes relevant to our eligibility criteria, including changes to:
  - drug or supply costs.
  - clinical guidelines.
  - new versions or modifications to a drug or supply.

Drug and supply expenses are eligible for reimbursement only if incurred on or after the date of our approval.

The eligibility criteria relevant to our initial and ongoing evaluation of drugs and supplies include:

- comparative analysis of the cost of the drugs or supplies and their clinical effectiveness.
- recommendations by health technology assessment organizations.
- coverage under government programs.
- availability of other drugs and supplies 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 you and your doctor to complete and submit an exception form.

Prior authorization program

The prior authorization (PA) program applies to select drugs and supplies which require prior approval before a claim is reimbursed. For your claim to be reimbursed, you must meet the clinical criteria determined by us.

We will assess if you meet the clinical criteria based on information provided by you and your attending doctor. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.

If you submit a claim for a drug or supply included in the PA program without obtaining prior approval, your claim will be declined.

Our prior authorization forms are available from the following sources:

- our website at www.mysunlife.ca/priorauthorization
- our Customer Care centre by calling toll-free 1-800-361-6212

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, drugs 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.

We will only cover emergency services obtained within 60 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services, drugs 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 (ETA) provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Sun Life's ETA provider 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 Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider 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.

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 Sun Life's ETA provider, 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. There is a limit of $25,000 per person during any 3 consecutive benefit years.

- 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 $125 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, 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.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.

We will also cover 50% of the costs for hearing aids prescribed by an ear, nose and throat specialist, up to a lifetime maximum of $5,000 per person. Repairs are included in this maximum. The deductible does not apply to these expenses.

Gender affirmation procedures

We will cover 100% of the costs for the following gender affirmation procedures, up to a benefit year maximum of $10,000 per person and a lifetime maximum of $40,000 per person, provided you meet the *Eligibility requirements* set out below.

Eligible procedures:

- breast augmentation/augmentation mammoplasty.
- thyroid chondroplasty.

- laryngoplasty.
- permanent hair removal (laser or electrolysis) for pre-surgical areas, or for excessive facial or body hair.
- brow bone reduction/construction.
- jaw bone reduction/reshaping/contouring.
- rhinoplasty, blepharoplasty and rhytidectomy.
- liposuction of the waist.
- gluteal augmentation (lipofilling or implants).
- hairline reconstruction to correct a receding hairline.
- hysterectomy.
- vaginectomy.
- salpingo-oophorectomy.
- chest contouring/chest masculinization, including liposuction/lipofilling done to provide additional contouring.
- implantation of penile and/or testicular prostheses.
- chin and cheek augmentation.
- pectoral implants.

We reserve the right to modify the above list of eligible expenses in the event there is a change in the list of procedures covered by any of the gender affirmation programs in a province or territory.

Eligibility requirements

- You must be under the care of a doctor for gender affirming care.
- You must be at least 18 years old and must have been diagnosed with gender dysphoria by a doctor.

- Prior approval is required. You and your doctor must complete the *Gender Affirmation application form*, and submit it to us.
- All procedures must be considered medically necessary by your doctor.
- All procedures must be performed in Canada.
- Only expenses incurred after your effective date for coverage under this benefit provision, and while this benefit provision is in force, will be eligible for reimbursement.

Before incurring an expense, you must call a Sun Life Financial Customer Care representative toll-free at 1-800-361-6212 to obtain the *Gender Affirmation application form*. We will assess all procedures based on the terms of this plan. We reserve the right to request details of procedures performed.

You may incur other expenses, such as drugs or paramedical services, related to gender affirming care. To determine if these other expenses are eligible under this plan, and any applicable benefit maximum, please refer to the *Prescription drugs*, *Paramedical services* or other applicable provisions of this Extended Health Care benefit.

What is not covered

We will not pay for the costs of:

- procedures payable or available under the medicare plan in your place of residence, regardless of whether you have applied to, or been accepted into, the gender affirmation program.
- travel or accommodations expenses.
- reversal of gender affirmation procedures.
- sperm preservation or cryopreservation of fertilized embryos.
- procedures related to fertility problems caused by gender affirming treatment and/or surgical care.

Paramedical services

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, social workers, psychiatrists or psychotherapists who are active members of a provincial association approved by Sun Life, except if the covered person's provincial plan prohibits payment of these expenses, up to a combined maximum of $3,000 per person in a benefit year.
- licensed massage therapists, when ordered by a doctor, up to a maximum of $1,200 per person in a benefit year.
- licensed physiotherapists.

We will cover 100% of the costs without a deductible, for each category of paramedical specialists listed below:

- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), naturopaths, podiatrists or chiropodists, up to a maximum of $300 per person in a benefit year, including a maximum of one x-ray examination per specialty each benefit year.
- licensed chiropractors, up to a maximum of $500 per person in a benefit year, 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 $500 per person in any 24 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 following the month in which the employee retires, reaches age 65 or employment terminates, whichever is earlier.** Coverage may also end on an earlier date, as specified in *General Information.*

**Coverage will be extended beyond this date provided you continue actively working at least 17.5 hours per week.

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, drugs 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, drugs or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services, drugs 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, drugs or supplies that are not usually provided to treat an illness, including experimental treatments.
- services, drugs or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- services, drugs 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, drugs or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services, drugs 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.

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.

Mental Health Coach

The services, provided by Sun Life's Mental Health Coach provider, are not insured or administered by Sun Life.

If you are covered for Extended Health Care coverage, you and your covered dependents will have access to the services offered through the Mental Health Coach. Only persons age 16 and over have access to these services.

The Mental Health Coach offers a mental health risk assessment and access to mental health coaches who are licensed healthcare professionals. To learn more about the services provided by Sun Life's Mental Health Coach provider, or to use these services, please visit sunlife.ca/mentalhealthcoach.

Liability and responsibility of Sun Life

Sun Life will not be held liable for any acts or omissions of any health care professional providing services directly or indirectly in connection with its Mental Health Coach provider.

Sun Life cannot guarantee the availability of its Mental Health Coach provider's services.

Emergency Travel Assistance

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Trent University.

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, Sun Life's Emergency Travel Assistance (ETA) provider can help.

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 60 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

The Medi-Passport coverage is subject to any maximum applicable to the emergency portion of the Extended Health Care benefit. The emergency services excluded from coverage, and all other conditions, limitations and exclusions applicable to your Extended Health Care coverage also apply to Medi-Passport.

We recommend that you bring your Travel card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.

Getting help

At the time of an emergency, you or someone with you must contact Sun Life's ETA provider. If contact with Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider 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.

Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card.

Sun Life's ETA provider may arrange for:

On the spot medical assistance

Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities.

As soon as Sun Life's ETA provider is notified that you have a medical emergency, its staff, or a physician designated by Sun Life's ETA provider, 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, Sun Life's ETA provider will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel.

Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Sun Life's ETA provider 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, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation.

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

Meals and accommodations expenses

If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Sun Life's ETA provider will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days.

Sun Life's ETA provider will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Sun Life's ETA provider, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.

Travel expenses home if stranded

Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live:

- for you, if due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated; or
- for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified attendant to accompany them home. The attendant is subject to the approval of you or a member of your family.

We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.

Travel expenses of family members

Sun Life's ETA provider will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the place where you are hospitalized if you are hospitalized for more than 7 consecutive days, and:

- you are travelling alone, or

- you are travelling only with a child who is under the age of 16 or mentally or physically handicapped.

We will pay a maximum of $150 a day for the family member's meals and accommodations at a commercial establishment up to a maximum of 7 days.

Repatriation

If you die while out of the province where you live, Sun Life's ETA provider will arrange for all necessary government authorizations and for the return of your remains, in a container approved for transportation, to the province where you live. We will pay a maximum of $5,000 per return.

Vehicle return

Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 for the return of a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from returning the vehicle.

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Sun Life's ETA provider will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

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 Sun Life's ETA provider coordinate the whole process with most provincial plans and all insurers, and send you a payment for the eligible expenses. Sun Life's ETA provider 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.

Limits on advances

Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.

The maximum amount advanced will not exceed $10,000 per person per trip unless this limit will compromise your medical care.

Reimbursement of expenses

If, after obtaining confirmation from Sun Life's ETA provider that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.

To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Sun Life's ETA provider:

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.
- amounts paid for services or supplies not covered by this plan.
- amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

Limits on Emergency Travel Assistance coverage

There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before your departure.

Sun Life's ETA provider reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- the refusal of authorities in the country to permit Sun Life's ETA provider to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Sun Life's ETA provider

Neither Sun Life nor Sun Life's ETA provider will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Care

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Trent University.

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 and customary charges. 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 January 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.

Reasonable and customary charges mean:

- charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined 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 reasonable and customary 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 or an orthodontic procedure. For other 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.

Lifetime maximum

The maximum amount we will pay for all Major dental procedures in a person's lifetime is $2,500.

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $3,000.

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 9 months.

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 9 months.

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 9 months.

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 9 months.

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.

For scaling and root planing, up to a combined maximum of 2 units of 15 minutes per benefit year for a child under age 13 or 10 units of 15 minutes per benefit year for any other person.

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

Repair Repair of bridges or dentures.

Rebase or reline Rebase or reline of an existing partial or complete denture.

Professional visits.

Major dental procedures

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

We will pay 50% of the eligible expenses for these procedures.

Major restorations Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).

Prosthodontics Construction and insertion of bridges or standard dentures. Limited to teeth extracted while a person is covered under this provision, until the person has been covered for 12 consecutive months. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

- it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.
- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Implants Implants, including surgery charges.

Orthodontic procedures

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

We will pay 50% of the eligible expenses for these procedures.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

When coverage ends

Dental Care coverage will end on the last day of the month following the month in which the employee retires, reaches age 65 or employment terminates, whichever is earlier.** Coverage may also end on an earlier date, as specified in *General Information.*

**Coverage will be extended beyond this date provided you continue actively working at least 17.5 hours per week.

Payments after coverage ends

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.

What is not covered

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstruction (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).
- 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. 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.

Long-Term Disability

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Trent University.

General description of the coverage

Long-Term Disability coverage 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 covered, and
- you have been following appropriate treatment for the disability since its onset.

For your Long-Term Disability coverage,

- during the elimination period and the following 24 months (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 job, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to earn at least 66 2/3% of your pre-disability basic earnings.

If you have 35 or more years of employment with your employer, you will be considered totally disabled while you are prevented by illness from performing the essential duties of your own occupation.

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

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

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for a period of 6 months accumulated over 12 months.

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

If you become totally disabled during a lay-off or approved leave and your coverage 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 a period of 6 months accumulated over 12 months and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

Here is how we calculate your Long-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take 75% of your monthly basic earnings up to a maximum of $13,000.

Step 2: We subtract any income provided to you:

- in connection with the same or a subsequent disability under any government-sponsored plan*, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.
- under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- for any work for wage or profit, except as approved by Sun Life.
- from any employer for the same or a subsequent disability.
- under a group plan, including any coverage resulting from your membership in an association of any kind.

- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.
- under the Québec Parental Insurance Plan.

*If you first become entitled to Québec Pension Plan (QPP) disability benefits:

- before age 60, we will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.
- on or after age 60, we will deduct the amount provided in your NOE and an additional amount. The additional amount represents a portion of the retirement amount, payable or available following an approved QPP disability application, and is comparable to the variable portion of QPP disability benefits for persons under age 60. These deducted amounts will not change for the duration of your disability claim.

If you are entitled to any of the amounts described above, we will estimate the amount of such benefits or income and deduct the estimated amount from your monthly disability benefit when you:

- fail to apply for the benefits or income, or exhaust all levels of appeal.
- fail to make a new application, following a declined application or appeal.
- refuse to receive or accept some or all of the benefits or income, or choose to cancel them.
- fail to provide us with information related to:
    - the status of an application, appeal or reapplication,

- the benefit or income amount, even if it has been refused or cancelled,

within 30 days of our request for information.

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

We 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.

We have the right to adjust your benefit payments when necessary.

Your Long-Term Disability payment will be increased in January of each year to reflect the average increase, if any, in the Canadian Consumer Price Index over the 12 month period ending 3 months prior to the date of any adjustment. Any percentage increase to your benefit payment cannot exceed 2%. In the event of deflation, we will not decrease your benefit payment.

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 a period of 6 months accumulated over 12 months, provided your coverage 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 our 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 an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long-Term Disability payments plus income from other sources. However, 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 elimination period, it will not be considered an interruption of the elimination period.

Any expense associated with an approved rehabilitation program, other than normal employment expenses, will be paid by Sun Life as long as Sun Life approves the expenses in writing in advance. The maximum

amount during any one period of disability will be 3 times the amount of the monthly Long-Term Disability payment.

Expenses will not be covered if Sun Life notifies you in writing that the rehabilitation program is no longer approved or that it will no longer accept previously approved expenses.

The rehabilitation program will end on the earlier of the following:
- 24 month following completion of the waiting period.
- discontinuance of the program
- withdrawal of Sun Life's approval for the program, and
- the end of the maximum benefit period.

Residual benefits

If you engage in any occupation for wage or profit after completing a rehabilitation program, you may receive reduced monthly Long-Term Disability payments equal to 30% of your pre-disability insured earnings. These payments are called residual benefits, and can be paid for up to a maximum period of 18 months.

If during any month your total income from all sources is more than 100% of your pre-disability basic earnings (less provincial and federal income taxes if your benefit is non-taxable), your residual benefit will be reduced by the excess.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again due to the same or related causes, we 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 covered when total disability reoccurs.

These benefits will be based on your coverage 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.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us the amount for the loss of income recovered from the third party, or the total disability income benefits paid or payable to you under this plan, whichever is less.

We have the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

Your responsibilities

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

- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits or income that may be available from other sources.

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

When payments end

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

- the date you are no longer totally disabled.
- if you become totally disabled prior to age 65 – the last day of the month in which you reach age 65, or until the end of a maximum benefit period of 2 years, but not beyond the last day of the month in which you reach age 70, if you have not already received 24 months of Long-Term Disability payments when you reach age 65.
- if you become totally disabled after you reach age 65 – the end of a maximum benefit period of 2 years, but not beyond the last day of the month in which you reach age 70.

- the last day of the month in which you retire on pension with the employer.
- the last day of the month in which you die.
- for an employee appointed on a limited term basis, 2 years after the expiry of the term appointment.

When coverage ends

Long-Term Disability coverage will end on the last day of the month in which you reach age 70 less the elimination period of 6 months accumulated over 12 months or the day you retire, whichever is earlier.

For an employee appointed on a limited term basis, the date the term appointment expires.

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

Payments after coverage 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.

What is not covered

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are not participating in an approved rehabilitation program, if required by Sun Life.

We 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.

When and how to make a claim

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

We must receive notice of claim on the earlier of the following dates:

- 30 days before the end of the elimination period.
- 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 us 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, we must receive these forms no later than 90 days after the end of the elimination period.

We will assess the claim and send you or your employer a letter outlining our decision.

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

Life Coverage

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Council of Ontario Universities.

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

Basic Life coverage for you

Amount

Your Life benefit is 1.5 times your annual basic earnings.

Reduction

Your benefit will reduce to 50% of the above amount (rounded to nearest $1,000) when you reach age 65. The maximum benefit will be $50,000.

Coverage ends

Your coverage will end when you reach age 70. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount

You can choose 1, 2, 3 or 4 times your annual basic earnings.

Overall maximum

The maximum amount of coverage for your basic and optional benefits combined is $1,000,000.

Reduction

Your benefit will reduce to 50% of the above amount (rounded to nearest $1,000) when you reach age 65. The maximum benefit will be $100,000.

Coverage ends

Your coverage will end when you reach age 70. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your

beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

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.

Suicide

If you have any optional coverage that has been in effect for less than 2 years, we will not pay benefits for these amounts if death is by suicide, regardless of whether you have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

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

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

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage 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, or
- the elimination period for Long-Term Disability if you are entitled to Long-Term Disability payments, whichever is shorter.

This coverage will continue without payment of premiums, from the date total disability begins, 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.

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by 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 benefit, you are also considered to be totally disabled under the Life benefit.

Converting Life coverage

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

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

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

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your employer.

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*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.