

District School Board of Niagara

(Maintenance and Caretaking Employees Local 4156)

*Group Plan No. 83620/25456
(Division 3)*

Your Group Insurance Booklet

Keep in a safe place

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

Your Plan Administrator is there to help

Your plan administrator can:

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

Benefits and claims information at your fingertips

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

We're on the Internet!

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

Our address is:

www.sunlife.ca

Respecting Your Privacy

Within the Sun Life Financial group of companies, 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 and investment products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees and representatives who are responsible for the administration and servicing of your contract(s) with us, or any other person whom you authorize. 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 Web site at www.sunlife.ca, call 1 800 361-6212, or 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 to request that a copy of our Privacy Brochure be sent to you.

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

Summary of Insurance

Policy Number 83620-3 - Life and Long Term Disability Insurance

Basic Life Insurance

Class of Members	Benefit Formula	Maximum Benefit
Eligible Maintenance and Caretaking Employees (Local 4156)	2x annual earnings	\$200,000

Termination of Insurance:

The earlier of:

- the end of the School Year in which you reach your 65th birthday, or
- the end of the month in which employment terminates, whichever is earlier.

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
Eligible Maintenance and Caretaking Employees (Local 4156)	60% of monthly earnings	\$2,600

Basic Reductions: CPP/QPP benefits (**excluding** benefits for dependent children) and Workers' Compensation, Workplace Safety and Insurance Act or similar legislation's benefits.

Total Disability and Totally Disabled: mean that,

- during the qualifying period and the 24 month period immediately following it, you have a medical impairment due to injury or disease which prevents you from performing, in any setting, the essential duties of the occupation in which you participated just before the total disability started, and
- after the 24 month period, you are unable, because of the medical impairment, to perform, in any setting, the essential duties of any occupation for which you have at least the minimum qualifications.

The medical impairment must be supported by objective medical evidence.

The availability of work for you does not affect the determination of totally disabled or total disability.

Qualifying Period: 6 months or the expiration of sick leave benefits, whichever is later

Benefit Period: To your 65th birthday, except if benefit payments begin during the 12 month period immediately before your 65th birthday, benefit payments will continue during the disability up to a maximum of 12 months.

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

Summary of Benefits

Plan Number 25456-3 – Health and Dental Benefits

Extended Health

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Drug: Pay Direct	*	100%	--
B	Vision: \$200**	none	100%	--
C	Hospital: ward to semi-private (optional)	none	100%	--
D	Supp. Health Care	none	100%	--
E	Out-of-Province Emergency and Travel Assistance	none	100%	\$1,000,000***

*The dispensing fee is limited to \$8.00 per prescription.

**Maximum for eyeglasses/contact lenses in any 2 consecutive calendar years for you and for each covered dependant.

***The maximum lifetime amount payable applies to eligible expenses incurred under Part E for you and for each covered dependant.

Other maximums are listed under the appropriate Provision page.

Termination Date:

The earlier of:

- the end of the School Year in which you reach your 65th birthday,
- the end of the month in which employment terminates, whichever is earlier.

Dental

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Preventive	none	100%	none

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

Termination Date:

The earlier of:

- the end of the School Year in which you reach your 65th birthday,
- the end of the month in which employment terminates, whichever is earlier.

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

General Information

Eligibility

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

1. You regularly work for District School Board of Niagara and are eligible in accordance with the provisions of the applicable collective agreement.
2. You are a resident of Canada.

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

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

Definitions

Dependant

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

Dependent child

means a natural, adopted or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on you for maintenance and support and who is

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

He, his and him

refer to both genders.

Spouse

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

Enrolment

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

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

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

Effective Date

Your coverage is effective on the date you become eligible.

Your dependant coverage is effective on the latest of

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

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

Changes in Coverage

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

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

Subrogation

Subrogation is a legal practice giving Sun Life the right to be reimbursed for benefits paid to you if you have been compensated by another person who is responsible for your loss. The intent of subrogation is to limit your benefit payments to the amount you actually lost.

Let's assume a person is responsible for your disability, and is required to compensate you for any of the loss that results from your disability. If Sun Life is paying or has paid your loss of income benefits, you may be receiving more income than you earned before you became disabled. In that case, you would reimburse Sun Life for the loss of income benefits Sun Life has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Sun Life.

Subrogation also applies to any medical and/or dental expenses you have been paid as a result of an injury caused by another person. Once you are compensated by the person who is responsible for your loss, you must reimburse Sun Life.

If subrogation applies to your claim, Sun Life will contact you to obtain the information required to proceed. You will be required to sign an undertaking to reimburse Sun Life for any amount recovered which exceeds 100% of income or expenses. Before agreeing to a settlement of your claim, Sun Life's approval must be obtained.

Comparable Coverage

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

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

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

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

Termination of Coverage

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

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

Member Life Insurance Provision

Benefit

The amount of benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or if the beneficiary has predeceased you, payment will be made to your estate.

If you become totally disabled before age 65, your Life Insurance may be continued. Premiums for the continued insurance will be waived after you have been totally disabled from the same or related causes for six continuous months or, if you are also insured for group Long Term Disability Insurance with Sun Life, when you begin receiving group Long Term Disability payments.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. The claimant must submit proof of the claim and the right to receive the benefit to Sun Life.

If you become totally disabled and are also insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim along with your claim under the group Long Term Disability Insurance to Sun Life.

If you become totally disabled and are not insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim to Sun Life after you have been totally disabled continuously between 6 and 12 months.

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

At Termination

If your Life Insurance terminates because you are no longer eligible, and this provision continues in force, you may convert it to an individual policy on your life up to the lesser of

- the amount of the insurance terminated,
- the maximum amount of insurance for which you have been insured under this provision less the total amount of individual insurance still in force on your life which was previously obtained through the Conversion Privilege of this provision, or
- \$200,000.

If your insurance terminates while this provision continues in force and you die within 31 days after termination of insurance, the amount of insurance terminated will be paid to your beneficiary.

If your Life Insurance terminates because this provision terminates, and you have been continuously insured under this provision for the five year period before the termination of this provision, you may convert it to an individual policy on your life up to the lesser of

- the amount of the insurance terminated less the amount of insurance in force under a new group policy that replaces this policy, or
- 3 times the Year's Maximum Pensionable Earnings as established under the Canada Pension Plan in the year that this provision terminated.

If you convert your Life Insurance, you must apply and pay the premium to Sun Life within 31 days after termination of insurance.

If you have any questions about this conversion privilege, please contact your plan administrator or the nearest Sun Life office.

Long Term Disability Insurance Provision

Benefit

The amount of monthly disability benefit will be paid to you when proof is received by Sun Life that you are absent from active work because you are totally disabled and that you have been totally disabled from the same or related causes for the qualifying period.

Benefits are payable from the later of

- one month after the end of the qualifying period, or
- one month after the date you are no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan.

If you are receiving disability income or retirement income from other sources, the monthly disability benefit will be reduced so that the total amount of disability and retirement income receivable by you from all sources does not exceed 85% of your monthly rate of earned income in force on the date you became totally disabled.

If the benefit is not subject to income tax, the monthly rate of earned income, for the purposes of this section, is reduced by income tax deductions.

If you become totally disabled, your Long Term Disability Insurance may be continued without payment of premiums while you are receiving Long Term Disability benefit payments.

Rehabilitation

If your total disability prevents you from returning to work, Sun Life may be able to assist you by providing a rehabilitation program that will help you return to the workforce. A rehabilitation program is limited to one or more of the following:

1. assessment,
2. counselling,
3. vocational retraining or an educational program,
4. trial work, part-time or modified work.

If, after qualifying for benefits, you are receiving income from an approved rehabilitation program, your monthly disability benefit is reduced by 50% of that income. Your monthly disability benefit is further reduced so that the total income from all sources does not exceed 100% of your

- gross monthly earnings in force on the date you became totally disabled, if the benefit is subject to income tax, or
- net monthly earnings, in force on the date you became totally disabled, if the benefit is not subject to income tax.

Example:

Assume you are earning \$2,000/month and have a 66 2/3% LTD benefit (\$1,334.00). Rehabilitation income from your employer is \$1,000/month. There is no income from other sources.

$$\begin{aligned} & \text{Rehabilitation Income} + (\text{Monthly Disability Benefit} - 50\% \text{ of Rehabilitation Income}) \\ &= \$1,000 + (\$1,334.00 - \{50\% \text{ of } \$1,000\}) \\ &= \$1,000 + \$834.00 \\ &= \$1,834.00 \end{aligned}$$

Since the benefit (\$1,834.00/month) does not exceed your pre-disability monthly earnings (\$2,000/month), there will be no reductions due to the 100% all source maximum.

If you are participating in a rehabilitation program approved by Sun Life, you continue to be considered totally disabled.

Claims

A claim must be received by Sun Life within 3 months after the end of the qualifying period. The qualifying period begins on the date you become totally disabled. Proof of continuing disability may be required each year.

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

At Termination

If this Long Term Disability provision terminates while you are totally disabled, you will continue to be eligible for this benefit as if it were still in force.

Exclusions and Limitations

No benefit is payable for a disability due to

- intentionally self-inflicted injuries,
- civil disorder or war, whether or not war was declared,
- committing or attempting to commit a criminal offence.

You are not considered totally disabled unless you are under the active and continuous care of a physician whom Sun Life considers to be appropriate to your total disability and you are following the treatment prescribed by the physician for that disability.

You are not considered totally disabled due to the use of drugs or alcohol unless you are being actively supervised by and receiving continuous treatment for that disability from a rehabilitation centre or an institution provincially designated for that treatment.

Extended Health Provision

Benefit

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

1. the maximums described throughout the extended health benefit provisions are applied,
2. then the deductible, which must be satisfied each **calendar** year, is subtracted, and
3. the reimbursement percentage is applied.

Example:

Assume that your plan has a \$25 deductible and a reimbursement level of 80%. The maximum that your plan covers for eyeglasses is \$175 every 24 month period. You have submitted an eyeglass claim for \$100. This is the first extended health claim you have submitted this year so the deductible does need to be paid by you.

To determine the amount that you would be refunded for this claim:

1. The maximum eligible amount under the plan is \$175. Therefore, the amount of the claim that will be considered for payment is \$175.
2. The \$25 deductible is applied to the submitted amount of \$100. The amount has now been reduced to \$75.
3. The reimbursement level is 80%. This means that 80% of the remaining \$75 will be refunded to you. 80% of \$75 is \$60. \$60 will be paid to you for this eyeglass claim.
4. The maximum eligible amount under the plan is \$175. \$175 less the \$100 that you submitted for this eyeglass claim is \$75. This means that \$75 will still be considered for payment for other eyeglass expenses during this 24 month period.

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

Co-ordination of Benefits

If you or your covered dependant are covered under another plan and the other plan does not contain a co-ordination of benefits clause, payment under the other plan must be made first.

If the other plan does contain a co-ordination of benefits clause, priority of payment will be attributed in the following order:

Member

1. The plan where the person is covered as a member,
2. If a person is covered under two plans, priority goes to
 - the plan where the member is a full-time employee,
 - the plan where the member is a part-time employee,
 - the plan where the member is a retiree.

Spouse

3. The plan where the person is covered as a member.

Dependent Child

4. The plan of the parent with the earlier birthdate (month/day) in the calendar/benefit year.
5. The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate.
6. In situations where parents are separated/divorced, then the following order applies,
 - the plan of the parent with custody of the dependent child,
 - the plan of the spouse of the parent with custody of the dependent child,
 - the plan of the parent not having custody of the dependent child,
 - the plan of the spouse of the parent not having custody of the dependent child.

If a dental accident occurs, health plans with dental accident coverage will pay benefits before dental plans.

If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amount that would have been paid under each plan had there been coverage by only that plan.

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

Claims

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

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

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

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to intentionally self-inflicted injuries,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
- expenses for which benefits are payable under a government plan,
- expenses for benefits which are legally prohibited by the government from coverage,
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

At Termination

If, on the date of termination of your coverage,

- you have a medically determinable physical or mental impairment due to injury or disease which prevents you from performing the regular duties of the occupation in which you participated just before the impairment started, regardless of the availability of work for you, or
- your covered dependant has a medically determinable physical or mental impairment due to injury or disease, is receiving treatment from a physician and is confined to a hospital or his home,

benefits will be payable for eligible expenses related to the impairment provided they are incurred within 90 days of the date of termination and this provision continues in force.

If you die, your covered dependant's Extended Health Benefits will be continued for 3 months, as long as the Extended Health provision remains in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

Health Coverage Choice

If your coverage under this plan terminates and you are under age 75, you may purchase Sun Life's Health Coverage Choice product. This coverage is different from your group plan.

To be eligible, you must

- apply for the Health Coverage Choice product within 60 days after the termination of your coverage, and
- be a resident of Canada and covered under the provincial health plan.

The Health Coverage Choice product that you apply for may also include Dental coverage if you had both Extended Health and Dental Benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependants if those family members were covered under your group plan.

If you have any questions about this product, you can contact us through:

- our Customer Service Centre at 1 800 SUN-LIFE (1 800 786-5433)
- e-mail sent to servicenow@sunlife.com
- our Web site at www.sunlife.ca/healthreplacement

Extended Health - Pay Direct Drug Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense, provided they are prescribed by a physician or dentist and dispensed by a registered pharmacist.

1. drugs which legally require a prescription and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription.
2. life-sustaining drugs which may not legally require a prescription and are identified in the Therapeutic Guide section of the current Compendium of Pharmaceuticals and Specialties under the following headings:
 - anti-anginal agents
 - antiparkinsonism agents
 - bronchodilators
 - antihyperlipidemic agents
 - hyperthyroidism therapy
 - parasympathomimetic agents
 - tuberculosis therapy
 - anticholinergic preparations
 - anti-arrhythmic agents
 - glaucoma therapy
 - insulin preparations
 - oral fibrinolytic agents
 - potassium replacement therapy
 - topical enzymatic debriding agents
3. injectible drugs.
4. compounded prescriptions where one of the ingredients is an eligible expense.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.

Generic Substitution

The maximum amount payable for an eligible brand name drug will be limited to the lowest priced item in the appropriate generic category.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your insured dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Claims

Claims for the above eligible expenses are submitted using a Pay Direct Drug card.

Claims for the following eligible expenses must be submitted directly to Sun Life by the member:

1. expenses for vaccines and preventive inoculations,
2. patent drugs, provided a physician certifies in writing that the drugs are required for continuous treatment of an ongoing disease or medical condition.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,

2. the yearly or per prescription deductible on drugs that are eligible under the Ontario Drug Benefit plan and are purchased by you or your insured spouse who is age 65 or over,
3. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
4. expenses for drugs which, in Sun Life's opinion, are experimental,
5. expenses for dietary supplements, vitamins and infant foods,
6. expenses for contraceptives, other than oral,
7. expenses for drugs which are used for cosmetic purposes,
8. expenses for drugs for the treatment of obesity,
9. drugs for the treatment of erectile dysfunction, and
10. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health - Vision Care Benefit

Definitions

Ophthalmologist

means a person licensed to practise ophthalmology.

Optometrist

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

Reasonable and customary charges

mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred or, for eligible expenses incurred outside Canada, the general level of charges for comparable services in the area where the member normally resides.

Eligible Expenses

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

1. eye examinations by an optometrist limited to one exam in a 24 month period (12 month period for a covered dependant under age 18).
2. eyeglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Benefits for eligible expenses incurred during the previous 2 calendar years for the member and each covered dependant.
3. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to \$150 for the non-surgical treatment of keratoconus for the lifetime of the member and each covered dependant and \$150 for each surgical procedure.

Exclusions

No benefit is payable for

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

Preferred Vision Services (PVS)

The Preferred Vision Services (PVS) vision care program enables you to purchase eyewear at savings of up to 20%. These savings are available on all frames, prescription lenses and lens add-ons at registered PVS locations. Most locations will also apply the discount to non-prescription eyewear and accessory items. This provision applies if your plan has extended health coverage. You do not have to be insured for Vision Care benefits to receive the discount.

PVS locations can be identified by calling the PVS information centre toll-free number 1-800-668-6444. After selecting your eyewear, tell the practitioner that you are covered under a plan through Sun Life (proof of plan membership may be required) and pay the reduced price. If you have vision care coverage, submit your claim to Sun Life.

Extended Health - Supplementary Hospital Benefit

Definitions

Hospital

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

Reasonable and customary charges

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

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the items listed below:

1. semi-private accommodation in a hospital, limited to the difference between the charges for public ward and semi-private accommodation for each day of hospitalization. Coverage is provided for semi-private accommodation both inside and outside the member's province of residence and Canada.

Exclusions

No benefit is payable for

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

Extended Health - Supplementary Health Care Benefit

Definitions

Chiropractor

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

Hospital

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

Naturopath

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

Osteopath

means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association.

Physiotherapist

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

Podiatrist

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

Psychologist

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

Reasonable and customary charges

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

Registered Massage Therapist

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

Registered Nurse

means a nurse who is listed on the appropriate provincial registry.

Speech Therapist

means a person who holds a diploma or degree in Speech Therapy from a recognized university.

Eligible Expenses

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

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

1. the services of a registered nurse (R.N.) provided in the patient's home.

2. rental, or purchase at Sun Life's option, of wheel chair, hospital bed, walker and other durable equipment approved by Sun Life and required for temporary therapeutic use.
3. trusses, crutches and braces, **with a limit of 4 pairs of elastic support stockings in a calendar year.**
4. artificial limbs or other prosthetic appliances, including colostomy supplies, and following a mastectomy, two surgical brassieres in any calendar year.
5. oxygen.
6. diagnostic laboratory and x-ray examinations.
7. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, when the physical condition of the patient prevents the use of another means of transportation.
8. emergency ambulance service by a licensed ambulance, air ambulance, or by any other vehicle normally used for public transportation, to the nearest hospital equipped to provide the required treatment, limited to one return trip in a calendar year and limited to the charge made in the area where the expense is incurred. Licensed ground ambulance service to and from the points of departure and arrival is also considered eligible.
9. hearing aids and repairs to them, excluding batteries, limited to \$200 during any 2 consecutive calendar years.
- 10. wigs, as a result of chemotherapy.**
11. the following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence.
 - a. public ward accommodation and auxiliary hospital services in a general hospital limited to, after deducting the amount payable by a government plan, \$75 a day for 60 days in a calendar year.
 - b. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

Items of expense incurred outside Canada are eligible only if they are not offered in any province in Canada

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

1. services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 6 months of the accident.
2. services of a chiropractor, osteopath and naturopath, provided no portion of a charge for these services is payable under a government plan, limited to \$20 per visit and \$250 in a calendar year for each practitioner. X-ray examinations taken by a chiropractor or osteopath are limited to \$15 in a calendar year.
3. services of a podiatrist, provided no portion of a charge for these services is payable under a government plan, limited to \$20 per treatment and \$250 in a calendar year. Services for surgical removal of the toe nails or plantar warts limited to \$100 in a calendar year.
4. services of a physiotherapist limited to \$20 per visit and \$200 in a calendar year.
5. services of a massage therapist limited to \$20 per visit and \$200 in a calendar year.
6. services of a speech therapist, limited to \$25 for the initial assessment and \$20 per visit for treatment or therapy, limited to \$200 in a calendar year.
7. services of a psychologist, limited to \$10 per one-half hour for the initial assessment and \$10 per visit for treatment or therapy, limited to \$200 in a calendar year.

The practitioner must be registered with the appropriate association or registry. Where applicable, expenses for practitioners' services eligible under a provincial health care plan will not be reimbursed until your expenses exceed the annual maximums under your provincial plan

8. custom made orthopaedic shoes, orthopaedic modifications to shoes and orthotics when they are required for the correction of deformity of bones and muscles and provided they are not solely for athletic use and are prescribed by a physician. Orthotics are limited to a maximum of \$250 per foot in a 24 month period.
9. hospital room and board charges for convalescent or chronic care limited to \$20 per day for each day of confinement.

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

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

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

Definitions

Emergency

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

Emergency services

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

Family member

means you or your covered dependant.

Reasonable and customary charges

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

Relative

means your spouse, parent, child, brother or sister.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact Sun Life's Emergency Travel Assistance provider, Worldwide Assistance Services, Inc. (Worldwide Assistance). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Worldwide 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 Worldwide Assistance cannot be made before services are provided, contact with Worldwide Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then we have the right to deny or limit payments for all expenses related to that emergency.

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

Emergency Services Excluded from Coverage

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

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

Eligible Expenses for Hospital/Medical Services

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

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

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

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

Eligible Expenses for Travel Assistance Benefits

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

1. family assistance benefits, which include reimbursement for the cost of:

- a. return transportation for covered dependent children who are under the age of 16, or who are handicapped, if they are left unattended because you or your spouse is hospitalized outside your province of residence. We will arrange the transportation of the dependent child to your home, and if necessary, an escort will be provided to accompany him. The maximum payable for the return transportation is a one-way economy fare for each dependent child.
- b. return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
- c. visit of one relative, if a family member is hospitalized for more than 7 days while travelling without a relative. This includes meals and accommodation up to a maximum of \$150 per day, and round-trip economy transportation, for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of his body.
- d. meals and accommodation up to a maximum of \$150 per day per family, if a trip is extended because a family member is hospitalized.

The combined maximum amount payable for the above family assistance benefits is \$5,000 for one travel emergency.

2. return of a deceased family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. The maximum amount payable for the preparation and return of the deceased is \$5,000. Preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased **includes** a basic shipping container, but **excludes** expenses for burial, such as burial caskets and urns.
3. return of a vehicle. If a family member is unable to operate a vehicle (owned or rented) because he is being returned to Canada for medical treatment, Sun Life will administer reimbursement of the cost of returning this vehicle to his province of residence, or the nearest appropriate rental agency. This benefit is also payable in the event of a family member's death. The maximum amount payable for returning the vehicle is \$1,000.

Travel Assistance Services

Out-of-province and around-the-world services are provided through Worldwide Assistance Services, Inc., a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Worldwide Assistance will be able to provide you and your covered dependants with the following emergency assistance services during the first 60 days of travel:

1. physician and hospital referrals,
2. on-going monitoring of medical treatment if a family member is hospitalized,
3. coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer him to another hospital that is equipped to provide the required treatment,
4. payment assistance for hospital/medical expenses,
5. legal referrals,
6. a telephone interpretation service,
7. a message service for you, your family, friends and business associates.

Emergency Payment Assistance

Eligible Hospital/Medical Expenses:

To ensure payment of these expenses,

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Sun Life travel assistance card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Worldwide Assistance will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your covered dependant.

3. You will be required to sign an authorization form allowing Worldwide Assistance to recover any amounts payable by the provincial health care plan.
4. For expenses that require a percentage paid by you, or that are not covered under this plan or the provincial health care plan, you must reimburse us for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Worldwide Assistance and they will coordinate payments with the provincial health care plan and Sun Life.

24 Hour Helpline

If emergency assistance is needed, a 24 hour helpline is available. Multilingual coordinators at Worldwide Assistance can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The 24 hour helpline can assist you and your covered dependant if you have lost your passport or visa, if you need to find a local legal advisor, or if you require telephone interpretation services. You can also call the helpline and leave important messages for family, friends or business associates; likewise, they can call the helpline and leave messages for you while you travel. Worldwide Assistance will hold such messages for 15 days.

When calling the 24 hour helpline, please be ready to state your Plan No., Certificate No., ID No., and Provincial Medical Insurance Plan/Health Card Number.

Please consult the telephone numbers on your travel assistance card.

Exclusions and Limitations

No benefit is payable for

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

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

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries. For more information on travelling conditions and the availability of Worldwide Assistance services in a particular country, please call the appropriate 24 hour helpline.

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

Dental Provision

Benefit

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

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

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

Sun Life reserves the right to refuse any assignment of benefits under this provision.

Co-ordination of Benefits

If you or your covered dependant are covered under another plan and the other plan does not contain a co-ordination of benefits clause, payment under the other plan must be made first.

If the other plan does contain a co-ordination of benefits clause, priority of payment will be attributed in the following order:

Member

1. The plan where the person is covered as a member,
2. If a person is covered under two plans, priority goes to
 - the plan where the member is a full-time employee,
 - the plan where the member is a part-time employee,
 - the plan where the member is a retiree.

Spouse

3. The plan where the person is covered as a member.

Dependent Child

4. The plan of the parent with the earlier birthdate (month/day) in the calendar year.
5. The plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birthdate.
6. In situations where parents are separated/divorced, then the following order applies,
 - the plan of the parent with custody of the dependent child,
 - the plan of the spouse of the parent with custody of the dependent child,
 - the plan of the parent not having custody of the dependent child,
 - the plan of the spouse of the parent not having custody of the dependent child.

If a dental accident occurs, health plans with dental accident coverage will pay benefits before dental plans.

If you or your covered dependant incurs expenses for the services of a dentist for the treatment of accidental injuries to teeth, payment for these expenses must be made under an extended health coverage plan that includes these expenses as eligible expenses, before payment will be made under this provision.

If priority cannot be established in the above manner, the benefits will be prorated in proportion to the amount that would have been paid under each plan had there been coverage by only that plan.

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

Claims

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

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

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

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

Exclusions and Limitations

No benefit is payable for

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

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with. Laboratory charges are also limited to 66 2/3% of the fee for the procedure in the Dental Fee Guide shown on the Summary of Benefits.

At Termination

If you die, your covered dependant's Dental Benefits will be continued for 3 months without payment of premiums as long as the Dental provision remains in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

Dental Provision - Preventive Benefit

Eligible Expenses

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

Procedures

- a. examination and diagnosis:
 - oral examination,
 - recall oral examination (once every 6 months for members and insured dependants 19 years of age and under and once every 9 months for members and insured dependants over 19 years of age),
 - special oral examination,
 - treatment planning,
 - emergency and unusual services,
 - consultation,
 - house call, institutional call and office visit,
- b. tests and laboratory examinations:
 - biopsy of oral tissue,
 - pulp vitality tests,
- c. radiographs:
 - periapical (one complete series every 2 years),
 - occlusal,
 - bitewing (once every 6 months for members and insured dependants 19 years of age and under and once every 9 months for members and insured dependants over 19 years of age),
 - extra oral,
 - sialography,
 - radiopaque dyes to demonstrate lesions,
 - panoramic (once every 2 years),
 - interpretation of radiographs received from another source,
 - tomography,
- d. preventive services:
 - dental prophylaxis (once every 6 months for members and insured dependants 19 years of age and under and once every 9 months for members and insured dependants over 19 years of age),
 - topical application of fluoride phosphate (once every 6 months for members and insured dependants 19 years of age and under and once every 9 months for members and insured dependants over 19 years of age),
 - pit and fissure sealant (for children under 19 years of age),
 - caries control,
 - interproximal discing,
- e. space maintainers:
- f. restorations:
 - amalgam,
 - acrylic or composite resin,
 - steel crown - primary teeth,
- g. endodontics:
 - pulpotomy,
 - root canal therapy,
 - periapical services,
 - other endodontic procedures,
 - emergency procedures,
- h. periodontics:
 - non surgical services,

- occlusal equilibration (not exceeding 8 time units every year),
- scaling and dentition,
- i. relining and rebasing of dentures:
 - repairs to bridges,
- j. denture repairs
- k. surgical services:
 - uncomplicated removals,
 - surgical removals and repositioning,
 - surgical excision,
 - surgical incision,
 - fractures,
 - lacerations,
 - frenectomy,
 - miscellaneous surgical services,
- l. major surgery:
 - alveoplasty,
 - excision of tumor,
 - dislocations,
- m. appliances to control harmful habits
- n. anaesthesia in connection with oral surgery and drug injections:

Exclusions

No benefit is payable for expenses incurred for the treatment of malocclusion or for orthodontic treatment.