Sun Life Financial

your group benefits

Region of Waterloo

The Regional Municipality of Waterloo

C.U.P.E. Local 1656

Group Policy No 82000-200 and 201
Effective March 1, 2026
Issued March 26, 2026

The Regional Municipality of Waterloo

Life, Long Term Disability
Extended Health and Dental Insurance

Underwritten by: Sun Life Assurance Company of Canada

Group Policy No. 82000-200 and 201

Accidental Death and Dismemberment Insurance
Underwritten by: The Citadel General Assurance Company

Group Policy No. 9216255

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Your Group Insurance Booklet

Keep in a safe place

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

Your Benefits Coordinator is there to help

Your Benefits Coordinator can:

- help you enrol in the plan
- provide you with the forms you need to claim group benefits
- answer any questions you may have
- assist you and your eligible dependants.

If you have any questions, please call 519-575-4742.

Benefits and claims information at your fingertips

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

We're on the Internet!

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

Our address is:

www.sunlife.ca

Accessing your records

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

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

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

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

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

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

The statements in this booklet are only a summary of some of the provisions in the master 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 benefits coordinator).

Summary of Insurance

Policy Number ***82000-200 and 201***

Life Insurance

Class of Members	Benefit Formula	Maximum Benefit
B1. Full Time Employees	2x regular earnings	$350,000
B10. Retirees under age 65	*	$350,000

Amount of Benefit:

- Class B1 - The amount of benefit is calculated by applying the benefit formula to the member's annual rate of earned income. This amount is rounded to the next higher $1,000 if not already a multiple of $1,000. It may not exceed the maximum benefit.
- Class B10 – The amount of benefit reduces to 2 times the member's annual OMERS Pension. This amount is rounded to the next higher $1,000 if not already a multiple of $1,000. It may not exceed the maximum benefit.

Termination of Insurance:
Class B1 - the end of the month following the member's 67th birthday
Class B10 - the end of the month following the member's 65th birthday

Long Term Disability Insurance

Class of Members	Benefit Formula*	Maximum Monthly Benefit
B1. Full Time Employees	70% of regular earnings	$10,000
B10. Retirees under age 65	--	--

***Reductions**: The Monthly Benefit amount may be reduced by benefits or payments from other sources as indicated under Benefit Reductions in the Long Term Disability Provision.

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

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

1. for which you have at least the minimum qualifications, and

2. That provides an income that is equal to or greater than the amount of monthly disability benefit payable under this provision, adjusted annually by the Consumer Price Index

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 : the later of 17 weeks or the expiration of sick leave credits, including sick leave credits accumulated during the qualifying period

If a member is participating in an approved rehabilitation program, the qualifying period may be satisfied while the member is working, subject to Sun Life's approval.

Benefit Period: to 65th birthday

Termination of Insurance: 65th birthday, less the qualifying period

Extended Health Insurance

Part	Benefit	Deductible per family unit	Reimbursement
A	Drug Benefit: Pay Direct*	none	100%
B	Vision: $600**	none	100%
C	Hospital: semi-private	none	100%
D	Supp. Health Care	none	100%
E	Out-of-Province Emergency and Travel Assistance	none	100%

*Reimbursement of the dispensing fee is limited to $13.00 per prescription.

**Maximum eligible expenses for eyeglasses/contact/laser eye surgery lenses in any 2 consecutive calendar years for you and for each insured dependant.

Termination of Insurance:
Class B1 - the end of the month following the member's 67th birthday
Class B10 - the end of the month following the member's 65th birthday

Dental Insurance

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/ Preventive	none	100%	--
B	Restorative - Implants	none none	100% 50%	-- $3,000*
C	Orthodontic	none	50%	$2,500**
D	Periodontic	none	100%	--
E	Denture	none	50%	$3,000*
F	Bridge	none	50%	*
G	Crown	none	50%	*
H	Endodontic	none	100%	--

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts B, E, F and G for you and for each insured dependant.

**The maximum lifetime amount payable applies to the eligible expenses incurred under Part C.

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

Termination of Insurance:
Class B1 - the end of the month following the member's 67th birthday
Class B10 - the end of the month following the member's 65th birthday

Dental Fee Guide: The applicable fee guide is the one in force for general practitioners on the day when the expense is incurred. For expenses incurred within Canada, the province where the expense is incurred determines the applicable fee guide, or, for expenses incurred outside Canada, the member's province of residence.

When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee established 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 are actively working for The Regional Municipality of Waterloo.
2. You regularly work for The Regional Municipality of Waterloo at least 40 hours each week.
3. You are a member of C.U.P.E. Local 1656.
4. You have been continuously employed by The Regional Municipality of Waterloo at least as long as the waiting period.
5. You are a resident of Canada.
6. You have Provincial Health Care coverage.

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

Participation is compulsory.

Waiting Period

- Long Term Disability - the equivalent of 6 months of actual hours worked
- All Other Benefits - the equivalent of 1 month of actual hours worked

Eligibility for Retired Employees

If you voluntarily elect *OMERS Early Retirement Pension*, you may be eligible for benefits (excluding Long Term Disability) until the end of the month following your 65th birthday. To be eligible, you must meet all of the following conditions:

1. You must be age 55 or over,
2. You were a member immediately prior to your retirement date,
3. You must be a resident of Canada, and
4. You have provincial Health Care coverage.

Any eligible benefits will be paid in accordance with the master policy.

Eligibility for Dependant Insurance

You are eligible, and continue to be eligible, for dependant insurance 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.
4. Your dependants have Provincial Health Care coverage.

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 insured 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 22 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.

Enrolment

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

If you request dependant insurance more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life.

If you are retired and request dependant insurance more than 31 days after you become eligible, the insurance will not be effective.

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

If your new dependant is a common-law spouse, see your Benefits Coordinator to find out how to enrol for dependant insurance.

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

Effective Date

Your insurance is effective on the date you become eligible.

Your dependant insurance is effective on the latest of

- the date that you become eligible for dependant insurance,

- the date that you request dependant insurance, 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 insurance or your dependant insurance would be effective, then that insurance will not be effective until the date you return to active work and satisfy the applicable waiting periods.

Changes in Insurance

An increase in your benefits, the amount of your insurance or the amount of your dependant insurance 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.

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

If you are not actively working on the date an increase in your benefits, the amount of your insurance or the amount of your dependant insurance 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 your dependant is insured 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 insurance 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 insurance 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 insurance will not be effective.

Termination of Insurance

Your insurance 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.

Active Employees – if you die, Extended Health and Dental benefits will continue for your eligible dependants for a period of 24 months, provided the dependants do not have such coverage from another source and these provisions remain in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

Retired Employees – if you are eligible for benefits and die before attaining age of 65, Extended Health and Dental benefits will continue for your eligible dependants, provided the dependants do not have such coverage from another source and these provisions remain in force. The coverage will remain in effect until the earlier of:

1. the dependants obtain Extended Health and Dental benefits from another source;
2. the surviving spouse remarries or enters into a common-law relationship; or
3. the last day of the month in which you would have attained age 65.

Your dependants must contact your Plan Administrator to arrange the extension of coverage.

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.

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.

If you become totally disabled before age 65, your Life Insurance may be continued until the end of the month following your 65th birthday. 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 for 6 months but not beyond 12 months after the date you became totally disabled.

Limitation period for Ontario:

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

Limitation period for any other province:

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

At Termination

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

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

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

Accidental Death and Dismemberment Insurance

Policy Number 9216255

Underwritten by: The Citadel General Assurance Company

Summary of Insurance

Class of Members	Benefit Formula	Maximum Benefit
B1. Full Time Employees	2x regular earnings	$350,000
B10. Retirees under age 65	*	$350,000

Amount of Benefit:

- Class B1 - The amount of benefit is calculated by applying the benefit formula to the member's annual rate of earned income. This amount is rounded to the next higher $1,000 if not already a multiple of $1,000. It may not exceed the maximum benefit.
- Class B10 – The amount of benefit reduces to 2 times the member's annual OMERS Pension. This amount is rounded to the next higher $1,000 if not already a multiple of $1,000. It may not exceed the maximum benefit.

Termination of Insurance: the end of the month following the member's 65th birthday.

Eligibility

Coverage applies if you are an active full-time employee, worker or nurse, up to the end of the month in which age 65 is reached, with the exception of persons described under Classes G2.

The Regional Municipality of Waterloo

Class A - All Management and Management Support employees & Retirees
Class B - CUPE Local 1656 employees
Class C - CAW Local 302 Sunnyside Home Service Workers
Class D - All ONA Local 15 - Sunnyside Home Registered Nurses
Class E - ONA Local 15 Community Health employees
Class G2 - Councillors
Class L - All C.U.P.E. Local 1883 (800) employees
Class U - CUPE Local 791 Ambulance employees

The Township of Woolwich

Class M - All employees

The Township of North Dumfries

Class N - All employees

The Township of Wellesley

Class O - All employees

Definitions

"Injury" means bodily injury caused by an Accident occurring while this policy is in force as to you, whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

"Accident" means any unlooked for mishap or untoward event which is not expected or designed.

"Sickness" means an impairment of normal physiological function and includes illness and infections.

"Disease" means any unhealthy condition of the body or any part thereof.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physicians available at all times and which continuously provides twenty-four (24) hour nursing service by graduate registered nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care.

"Regular Care and Attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

"Physician" means a doctor of medicine (other than you or an Immediate Family Member) who is licensed to practice medicine by:

1. a recognized medical licensing organization in the locale where the treatment is rendered,

   provided he is a member in good standing of such licensing body, or
2. a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Immediate Family Member" means a person at least eighteen (18) years of age, who is your son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), spouse, grandson, granddaughter, grandfather or grandmother.

"Motorized Vehicle" means a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

"Accommodation" means lodging in the vicinity of the Hospital where you are confined.

"Insured Person" means you who is an insured employee.

The male pronoun will be construed as the feminine when the person is a female.

Coverage

Coverage is provided for any Accident resulting in death, dismemberment, paralysis, loss of use, sight, speech or hearing - anywhere in the world - 24 hours a day - on or off the job.

Principal Sum

Two times annual salary, rounded to the next higher $1,000, to a maximum benefit of $350,000.

With respect to early retirees, the amount of Principal Sum is two times the annual OMERS Pension, rounded to the next higher $1,000, to a maximum benefit of $500,000 up to the end of the month in which age 65 is reached.

Benefits Provided

Specific Loss

If any of the following losses occur within 365 days after the date of the Accident, benefits will be paid according to the following schedule:

For Loss of	Percentage of Principal Sum
Life	100%
Entire sight of one eye	75%
Speech	75%
Hearing in one ear	40%
All toes of one foot	33 1/3%
For Loss or Loss of Use of	
One arm	80%
One leg	80%
One hand	75%
One foot	75%
Thumb & index finger or at least four fingers of one hand	40%
For Paralysis of	
Both upper & lower limbs (Quadriplegia)	200%

Both lower limbs (Paraplegia)	200%
Upper & lower limbs of one side of body (Hemiplegia)	200%

The amount payable for all losses sustained by any one insured as the result of any one Accident will not exceed the following:

a. with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.

b. with respect to quadriplegia, paraplegia and hemiplegia, 200% of the Principal Sum, or 100% if loss of life occurs within 90 days after the date of the Accident.

The aggregate amount payable for all losses as a result of the same Accident will not exceed 200% of the Principal Sum.

"Loss of Life" means the death of the Insured Person.

"Loss" as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb means the complete severance of one entire phalanx of the thumb; as used with reference to finger means the complete severance of two entire phalanges of the finger; as used with reference to toes mean the complete severance of one entire phalanx of the big toe and all phalanges of the other toes; as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

"Paralysis" means the loss of ability to move all or part of the body.

"Quadriplegia" means the permanent Paralysis and functional loss of use of both upper and lower limbs.

"Paraplegia" means the permanent Paralysis and functional loss of use of both lower limbs.

"Hemiplegia" means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Loss" as above used with reference to loss of use means the total and irrecoverable loss of use, provided the loss is continuous for twelve consecutive months and such loss of use is determined to be permanent at the end of such period.

Repatriation

If you sustain loss of life resulting from Injury for which an amount of Principal Sum becomes payable under the program, repatriation benefits up to $15,000 will be paid for expenses actually incurred for the return home of your body (including preparation charges for transportation). The death must occur more than 50 kilometres from your residence.

Education

If you sustain loss of life resulting from Injury for which an amount of Principal Sum becomes payable under the program, up to a maximum of 5% of your Principal Sum or $5,000, whichever is less, will be payable to your dependent children who are already enrolled as a full-time student in an institution for higher learning or who will do so within 365 days after your death.

The benefit is payable annually, for each year (up to 4 consecutive years) that the child remains enrolled as a full-time student in an institution for higher learning.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in an Institution for Higher Learning.

“Institution for higher learning” is limited to universities, colleges, CEGEPs and trade schools.

“Dependent Child” means a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Person. The child is unmarried, under twenty five (25) years of age [twenty-six (26) in the province of Québec] and dependent upon the Insured Person for maintenance and support.

Day-Care

If you sustain loss of life resulting from Injury for which an amount of Principal Sum becomes payable under the program, up to a maximum of 5% of your Principal Sum or $5,000, whichever is less, will be payable for reasonable and necessary expenses actually incurred by each of your dependent children who are enrolled in a legally licensed day-care centre or who will do so within 365 days after your death.

The benefit is payable annually, for each year (up to 4 consecutive years) that the child remains enrolled in a legally licensed day-care centre.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled in a legally licensed day-care centre.

“Day-care centre” means a facility which is operated according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-care centre will neither include a hospital, the child's home or care provided during normal school hours while the child is attending grades 1 through 12 nor any other day-care facility which does not charge a fee for services rendered.

“Dependent Child” means a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Person. The child is under 13 years of age and dependent upon the Insured Person for maintenance and support.

If none of your dependent children satisfy the requirements under either the Education or Day-Care Benefit, an amount equal to 5% of your Principal Sum or $2,500, whichever is less, will be paid to your beneficiary.

Rehabilitation

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program, this benefit will refund expenses incurred for your participation in a rehabilitation program in order to qualify in a different occupation, during the 3 year period following the date of loss, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Workplace Modification and Accommodation Benefit

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program, and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active full-time work with the Policyholder, this benefit will pay the reasonable and necessary expenses actually incurred by the Policyholder provided:

1. The Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs.
2. The Policyholder acknowledges in writing that the performance of the essential duties of your job may be altered.
3. The proposed special adaptive equipment and/or workplace modification must have prior written approval by the Insurer.
4. The Insurer has the right to examine you to evaluate the appropriateness of the proposed modifications.

The benefit will be paid to the Policyholder upon your return to active full-time work with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder will not exceed $ 5,000 as a result of any one Accident.

Occupational Training

If you sustain loss of life resulting from Injury for which an amount of Principal Sum becomes payable under the program, and your spouse must engage in a formal occupational training program in order to upgrade employment qualifications, this benefit will refund expenses incurred within 3 years following the date of your death, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

In the event your spouse does satisfy the requirements indicated above, such spouse will be deemed the beneficiary with respect to the benefits payable under this provision.

“Spouse” means an individual under age 65

a. to whom you are legally married or
b. with whom you have continuously cohabited in a conjugal relationship and is publicly represented as your spouse immediately before a loss is incurred under the program.

Only one individual will qualify as a spouse.

If you are legally married but are also cohabiting with an individual as described under section (b) above, you may elect in writing which one of the individuals will qualify as a spouse under the program. This election must be filed with the Policyholder. The Citadel will not be bound by an election not filed before the event insured against. If an election is not filed, the spouse will be the individual to whom you are legally married.

Permanent Total Disability

The Principal Sum will be paid to you in a lump sum, less any other amounts payable under the Specific Loss section as a result of the same Accident, if you become totally disabled and the following conditions are met:

- The disability results from an injury occurring prior to age 65.
- The disability commences within 365 days of the Accident.
- The disability prevents you from engaging in each and every occupation or employment for compensation or profit for which you are reasonably qualified by education, training or experience.
- The disability continues for 12 consecutive months, remains total and is permanent at the end of such period.

Family Transportation

If you sustain a specific loss for which an amount of Principal Sum becomes payable under the program, you are confined as an inpatient in a hospital which is located more than 150 kilometres from your residence, and you are under the regular care and attendance of a physician, this benefit

will refund expenses incurred by an Immediate Family Member for hotel accommodation and transportation (via the most direct route) to your bedside, to a maximum of $15,000. Private transportation expenses are limited to $0.25 per kilometre travelled.

Board or other ordinary living, travelling or clothing expenses are not covered.

Seat Belt

If you are driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt at the time of the Accident, and you sustain a specific loss for which an amount of Principal Sum becomes payable under the program, the amount payable for such specific loss is increased by 10%, subject to a maximum of $25,000.

The driver of the vehicle must hold a current and valid driver's licence and must not be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician, at the time of the Accident.

Home Alteration and Vehicle Modification

If you sustain the loss of or loss of use of both feet or legs or become quadriplegic, paraplegic or hemiplegic, for which indemnity is payable under the program, and subsequently require the use of a wheelchair to be ambulatory, this benefit will refund expenses incurred during the 3 year period following the date of loss, to a maximum of $15,000, for the cost of alterations to your principal residence and/or the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

The amount payable under this section will be co-ordinated with any amount which is paid or payable under any other insurance plan providing the same or similar benefit.

Hospital Indemnity

If an injury results in a specific loss being payable under the program and such injury confines you to a hospital and you are under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum, from the 1st day of hospitalization, to a maximum of $2,500 per month and for a maximum duration of 365 days per injury. All hospitalizations must occur within 730 days of the date of accident and should not be separated 90 days or more.

Hospitalization for treatment of any injury other than for a specific loss will also be covered in accordance with the above, but the daily benefit will only be payable from the 5th day of hospitalization. Hospitalization must commence within 365 days of the date of accident.

Only one period of hospitalization will be payable for all injuries sustained by you as the result of the same accident.

"Period of Hospitalization "means a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same accident, provided each such confinement is separated by a period of less than ninety (90) consecutive days and all such confinements occur within seven hundred and thirty (730) days of the date of the accident.

"Days of Hospitalization" means a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day's room and board is charged.

Note: Benefits marked with an asterisk (*) are only payable under one of the policies issued to the Policyholder by The Citadel.

Benefits marked with 2 asterisks (**) are subject to a combined maximum with similar benefits provided under any other policy issued to the Policyholder by The Citadel.

Aircraft Coverage

You are covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated or leased by or on behalf of the Policyholder) and flown by a licensed pilot. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered Accident.

You will be presumed to have suffered accidental loss of life if your body is not found within one year after the disappearance or sinking or wrecking of the conveyance in which you were riding at the time of the Accident.

Aggregate Limit of Indemnity

A maximum limit of $5,000,000 is imposed on the total of all losses arising out of any one Accident covered under the program.

This means that if you and any other persons insured under the program suffer losses occurring from the same Accident, and the total of all benefits (the benefit you are entitled to added to those which the others are entitled to) is greater than the aggregate limit of indemnity amount, then the amount of benefit payable to each individual will be proportionately reduced so that the total amount of all benefits payable equals $5,000,000.

This aggregate limit only applies to losses payable under the following sections:

Specific Loss Accident Indemnity
Permanent Total Disability Indemnity

Indemnity Payments

Your accidental death benefit is payable to the beneficiary you designate on your Basic Group Life enrollment card or the beneficiary or beneficiaries designated in writing by you for the Basic Group Life if changed at a later date. If there is no noted beneficiary, the benefit is payable to your estate. With the exception of Repatriation, Education, Day-Care, Workplace Modification and Accommodation, Occupational Training and Family Transportation benefits, all other benefits are payable to you.

Waiver of Premium

If, as the result of total disability, you are approved for waiver of premium and remain eligible for such under the terms of the Policyholder's Basic Group Life Insurance contract, the Policyholder need not pay any further premiums for you under this program.

Premiums will continue to be waived until the earliest of the following dates:

1. the date this program terminates;
2. the date you reach age 65; or
3. the date you cease to be totally disabled.

All terms and provisions of this program will apply during the period the premiums are waived, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in this program, in no event will benefits payable for any loss which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to you at the date of commencement of disability.

Continuation of Coverage

If under your employer’s Basic Group Life Insurance contract, your life insurance is continued during any approved leave of absence, temporary lay-off, maternity leave or disability leave, coverage under this program will also be continued in accordance with the same terms and conditions of the basic group life insurance contract, provided payment of premium is continued.

The coverage which is continued under this clause will be subject to the terms and provision of the policy in effect as of the date of commencement of the leave.

Notwithstanding anything contained to the contrary in this program, in no event will benefits payable for any loss which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to you at the date of commencement of your leave.

Extension of Coverage

If your employment is terminated by the Policyholder, your coverage will be continued for up to 12 months, provided such continuation is required by the Employment Standards Act and payment of premium is continued.

All terms and provisions of this program will apply as of the date of termination of employment, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in this program, in no event will benefits payable for any loss which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to you at the date of termination of employment.

Retirement

If you retire between the ages of 55 and 65, coverage may be continued until the end of the month following your 65th birthday, provided payment of premium is continued.

Coverage may be continued after age 65, subject to the following:

1. Your Principal Sum will be limited to a maximum of $500,000;
2. Your coverage will terminate at the end of the month that you reach age 65.

Note: The Permanent Total Disability indemnity is not payable after you retire. You cannot increase your amount of insurance after you retire and the amount of your insurance will be in line with the OMERS plan after the date you retire.

Conversion Privilege

Upon termination of insurance and provided the program is still in effect, you may convert your insurance, without evidence of insurability, into an individual accident policy.

You must apply prior to age 65 and within 31 days of the termination of your coverage.

The benefits provided will be a Specific Loss Accident Indemnity schedule available from The Citadel at the date of conversion, and the amount of insurance that may be converted will not exceed the amount of insurance then in effect on the date of termination or a total aggregate of $750,000 for all such conversions with The Citadel.

Premiums for such an individual accident policy being issued in compliance with the aforementioned condition will be calculated at The Citadel's manual premium rates then in force for your attained age at the date of conversion.

Premiums will be payable annually in advance and the individual accident policy will be issued on an annually renewable basis.

Effective Date of Insurance

Your insurance will take effect:

a. on the effective date of the program if you are eligible under your Basic Group Life Insurance Plan on or before such date;

b. on the date insurance under your Basic Group Life Insurance Plan becomes effective if such date is after the effective date of the program;

Termination Date of Insurance

Your insurance will immediately terminate on the earliest of the following dates:

1. on the date the program is terminated;
2. on the premium due date if the Policyholder fails to pay the required premium for you;
3. at the end of the month in which you reach 65 years of age;
4. on the date you cease to be an active employee of the Policyholder on account of leave of absence, lay-off, maternity leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections:

    Waiver of Premium
    Continuation of Coverage
    Extension of Coverage
    Retirement

Exclusions and Limitations

This program does not cover any loss, fatal or non-fatal, caused or contributed to by:

- suicide or intentionally self-inflicted Injury;
- war, whether declared or not;
- participation in a riot, insurrection, civil commotion or disturbance;
- active full-time, part-time or temporary service in the armed forces of any country;
- riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled "Aircraft Coverage"
- medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

Procedure for claims

You or your beneficiary must notify the Policyholder immediately of any injury for which you intend to file a claim.

In the event of a claim, written notice of injury must be given to The Citadel within 30 days after the date of the Accident, and written proof of loss must be submitted to The Citadel within 90 days after the date of such loss.

Failure to provide such notice or proof within such time will not invalidate nor reduce any claim, if it is shown not to have been reasonably possible to provide such notice or proof and that such notice or proof was provided as soon as was reasonably possible, but in no event later than one year after the date of the Accident.

This is a brief outline of the coverage and should be retained for reference only. The Master Policy sets forth in detail the terms and conditions of the program and all rights and obligations are determined in accordance with the Master Policy issued by The Citadel General Assurance, not this outline. For exact provisions of coverage, please contact the Policyholder.

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

- the end of the qualifying period, or
- 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 your employer pays any portion of the Long Term Disability premium, the benefit payable to you will be taxable.

Benefits are paid in arrears and will begin one month after you become eligible to receive them. A proportionate amount of the monthly benefit will be paid for each full day you are totally disabled for less than a full month, once you have qualified for benefits.

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

Benefit Reductions

All references to benefits and payments in this disability benefit provision are the gross amounts before deductions.

The monthly disability benefit is reduced by any benefits or payments, before deductions, under any government plan, law or agency, such as the Canada Pension Plan/Québec Pension Plan*, the Québec Parental Insurance Plan, the Workers' Compensation Act, Workplace Safety and Insurance Act, or other similar legislation, resulting from your same, subsequent or related disability, excluding benefits or payments on behalf of a dependant.

If the benefit payable to you is taxable, the monthly disability benefit will be further reduced so that the total amount of disability and retirement benefits and payments 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 payable to you is non-taxable, the 85% will be applied to your monthly rate of earned income reduced by income tax deductions.

"All Sources" include but are not limited to benefits or payments provided:

1. under another group insurance policy (including a policy under which you are insured because you belong to an association)
2. under an automobile insurance policy
3. under a retirement income plan providing income that becomes payable after you are no longer actively at work, whether or not the retirement income is related to disability

4. under any government plan, law or agency, such as the Canada Pension Plan/Québec Pension Plan, the Workers' Compensation Act, Workplace Safety and Insurance Act, or other similar legislation, resulting from your same, subsequent or related disability, excluding benefits or payments on behalf of a dependant.
5. under the Québec Parental Insurance Plan. For the purpose of this provision, all payments under the Québec Parental Insurance Plan will be treated in the same manner as payments resulting from the member's disability.

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

- before age 60, Sun Life will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.
- on or after age 60, Sun Life 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.

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

Benefits or payments from the following sources will not reduce the monthly disability benefit

1. a policy which is solely an individual disability policy
2. a disability attachment to an individual life insurance policy
3. a government plan providing disability benefits or payments if Sun Life receives proof that the initial application and an appeal filed within one year of the original decision to decline those disability benefits, have been declined.

Increases in the disability benefits or payments payable under a government plan may occur because of an automatic adjustment in the cost of living. These increases will not further reduce the amount of the monthly disability benefit.

If you are eligible for any of the benefits or payments described above, and do not make satisfactory application for them, Sun Life will still consider them when calculating the monthly disability benefit. Sun Life can estimate those benefits or payments and use them to calculate your monthly disability benefit.

Total benefits and payments from all sources will not be less than the amount of the disability benefit for which you are insured.

Rehabilitation

If your 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 can involve vocational retraining, educational programs and trial or part time work in a new or related field.

Partial Disability

A partial disability benefit will be paid to you if you are receiving income under an approved rehabilitation program. The partial disability benefit is your monthly benefit payable reduced by 50% of your monthly rehabilitation income. Your partial disability benefit will be further reduced so that the total amount of your income from all sources does not exceed 100% of your pre-disability income.

Example:

Assume you are earning $2,000/month and have a 70% LTD benefit ($1,400.00). Rehabilitation income from your employer is $1,000/month. There is no income from other sources.

= Rehabilitation Income + (Monthly Disability
Benefit minus 50% of Rehabilitation Income)
= $1,000 + (1,400 - {50% of 1,000})
= $1,000 + $900
= $1,900

Since the partial disability benefit ($1,900/month) does not exceed the pre-disability earnings ($2,000/month), there will be no reductions due to the 100% all source maximum.

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 total disability may be required as often as necessary.

If you are receiving Workers' Compensation, Workplace Safety Insurance Act or similar legislation's benefits, you must submit a claim for the monthly disability benefit.

There is a time limit for appealing Sun Life's decision to decline or terminate a claim. An appeal must be made within 3 months of such a decision and must be accompanied by new objective medical evidence.

Limitation period for Ontario:

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

Limitation period for any other province:

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

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.

Survivor Benefit

A survivor benefit will be paid to your designated beneficiary after your death. The benefit is equal to 3 times your last monthly disability payment.

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.

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.

Extended Health Insurance Provision

Benefit

To qualify for the Extended Health coverage, you or your dependant must be covered under a provincial medicare plan or federal government plan that provides similar benefits.

Reference to physician 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 physician. For the Drug Benefit, refer to *Other Health Professionals Allowed to Prescribe Drugs and Supplies.*

You will be reimbursed when you submit proof to Sun Life that you or your insured dependant has incurred any of the eligible expenses for MEDICALLY NECESSARY SERVICES required for the treatment of disease or bodily injury. An eligible expense is incurred on the date the services, drugs or supplies are received, purchased or rented, as applicable. 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 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.

Eligible expenses mean expenses:

1. incurred for the services, drugs and supplies:
    - medically necessary for the treatment of a disease or injury and

- meeting other requirements described below.

2. not exceeding the reasonable and customary charges for the service, drug or supply.

Supplies include equipment, devices and other similar items.

Co-ordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

Claims

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

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

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

Limitation period for Ontario:

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

Limitation period for any other province:

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

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services, drugs and supplies, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
- expenses for services, 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*,
- expenses for services, drugs or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- expenses for 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,
- expenses for services, drugs or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

Integration with Government Programs

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

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

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

At Termination

If, on the date of termination of your insurance,

- 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 insured 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/her 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.

My Health CHOICE Coverage

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

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

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

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

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

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

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

Extended Health – Pay Direct Drug Benefit

Definitions

Dentist
means a person licensed to practise dentistry by the provincial licensing authority.

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 pharmacist
means a person who is licensed to practise pharmacy and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.

Eligible Expenses

To be eligible under this benefit, 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, Sun Life will cover the reasonable and customary charges for the following, when prescribed by a physician or dentist and dispensed by a registered pharmacist or physician:

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
6. Continuous Glucose Monitoring (CGM) systems and their parts, including both intermittently scanned and real-time monitors, as determined by Sun Life, limited to a combined maximum of $4,000 in a calendar year, subject to any clinical criteria that Sun Life may require.
7. smoking cessation aids that legally require a prescription, limited to a lifetime maximum of $500 for you and for each insured dependant.
8. oral and non-oral contraceptives.

Evaluation of Drugs and Supplies

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

1. drugs when Health Canada issues a new or amended Notice of Compliance on or after November 1, 2017.
2. supplies initially made available for sale on the Canadian market on or after March 1, 2026.

3. 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 Sun Life's 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 Sun Life's approval.

The eligibility criteria relevant to Sun Life's initial and ongoing evaluation of drugs and supplies include:

1. comparative analysis of the cost of the drugs or supplies and their clinical effectiveness.
2. recommendations by health technology assessment organizations.
3. coverage under government programs.
4. availability of other drugs and supplies treating the same or similar condition(s).
5. plan sustainability.

Drug Substitution Limit

Charges in excess of the lowest priced equivalent drug are not covered, unless the physician or dentist has indicated no substitution on the prescription form.

Reference Drug Program

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category*.

For all *therapeutic categories*, the *Reference Drug Limit* applies to insured persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to insured persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.
- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the insured person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the insured person and the attending physician to complete and submit an exception form.

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.

Other Health Professionals Allowed to Prescribe Drugs and Supplies

If applicable provincial legislation allows:

1. other qualified health professionals to prescribe certain drugs or supplies, or
2. registered pharmacists, in providing pharmacy services, to recommend and dispense certain drugs and supplies,

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

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
3. expenses for services, drugs and supplies which, in Sun Life's opinion, are experimental,
4. expenses for dietary supplements, vitamins and infant foods,
5. expenses for drugs which are used for cosmetic purposes,
6. expenses for drugs used for the treatment of sexual dysfunction,
7. expenses for drugs used for the treatment of obesity,
8. smoking cessation aids that do not legally require a prescription,
9. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
10. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
11. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Vision Care Benefit

Definitions

Laser Eye Surgery

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

Ophthalmologist

means a person licensed to practise ophthalmology.

Optometrist

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

Reasonable and customary charges

mean those which are usually made to a person without 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.

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense:

1. eye examinations by an optometrist limited to one examination in a 24 month period (12 month period for an insured dependant under age 18).
2. eye glasses, contact lenses, repairs to them and laser eye surgery 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 Insurance in any two consecutive calendar years.
3. eye glasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to a lifetime maximum of $200 for the non-surgical treatment of keratoconus for you and each insured dependant and a maximum of $200 for each surgical procedure.
4. medical fees for eye injections by an ophthalmologist for macular disorders only, limited to a calendar year maximum of $1,500 for you and for each insured dependant.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.
2. the portion of expenses for which reimbursement is provided by a government plan.

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 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.

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.

Exclusion

No benefit is payable for

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

Extended Health – Supplementary Health Care Benefit

Definitions

Audiologist
means a member of the Canadian Speech and Hearing Association or of any provincial association affiliated therewith.

Chiropodist, Podiatrist
means a person licensed by the appropriate provincial licensing authority.

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

Clinical counsellor
means a person who is an active member of a provincial association approved by Sun Life.

Marriage or Family Therapist
means a person who is registered as a clinical member (C.M. or C.S.) with the Canadian Division of the American Association for Marriage and Family Therapy.

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

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

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

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

Psychotherapist

means a person licensed by the appropriate provincial licensing authority as a psychotherapist, or a person who is an active member of a provincial psychotherapy association approved by Sun Life.

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

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

Social Worker

means a person who holds a Master of Social Work (MSW) degree from an accredited university.

Speech Language Pathologist

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

Eligible Expenses - Miscellaneous

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense, PROVIDED THEY ARE PRESCRIBED BY A PHYSICIAN:

1. services of a registered nurse (R.N.) provided in the patient's home limited to $25,000 in a calendar year.
2. services of a registered speech language pathologist limited to $500 in a calendar year.
3. services of an audiologist limited to a maximum of $75 once every 36 months.
4. rental, or purchase at our option, of wheel chair, hospital bed, walker and other durable equipment approved by Sun Life and required for temporary therapeutic use.
5. trusses, crutches, braces and fibreglass casts.
6. braces, provided they are not solely for athletic use. Eligible braces include, but are not limited to back supports such as, OBUS Forme, Back Buddy etc., limited to one back support for the lifetime of the member and each insured dependant.
7. artificial limbs or eyes or other prosthetic appliances.
8. oxygen.
9. diagnostic laboratory and x-ray examinations.
10. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or from one hospital to another hospital, and from a hospital to the member or insured dependant's residence, when the physical condition of the patient prevents the use of another means of transportation.
11. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.
12. wigs required as a result of chemotherapy or radiation therapy limited to a lifetime maximum of $500 per person.

13. wigs required as a result of alopecia limited to an annual maximum of $350 per person.
14. 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 also mean REASONABLE AND CUSTOMARY charges for the following items of expense:

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 36 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident.
2. services of a registered massage therapist limited to 15 treatments in a calendar year. Each treatment is limited to a 1 hour maximum.
3. services of a registered chiropractor and one x-ray examination, limited to $1,000 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 be reimbursed before your expenses exceed the annual maximums under your provincial plan, starting from the first visit to the practitioner.
4. services of a registered osteopath, provided no portion of a charge for these services is payable under a government plan, and one x-ray examination, limited to $500 in a calendar year.
5. services of a registered naturopath, provided no portion of a charge for these services is payable under a government plan, limited to $500 in a calendar year.
6. services of a registered chiropodist or podiatrist, provided no portion of a charge for these services is payable under a government plan, and one x-ray examination, limited to $500 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.
7. services of a registered psychologist, social worker, psychotherapist, clinical counsellor or marriage or family therapist limited to a combined maximum of $1,250 in a calendar year.
8. services of a physiotherapist limited to $1,000 in a calendar year.
9. hearing aids and repairs to them, excluding batteries, limited to $2,000 every 3 years, each ear.
10. orthopaedic shoes which are part of a brace or are specially constructed for the patient, including modifications to these, provided that the shoes or modifications are prescribed by a physician, podiatrist or chiropodist, limited to $175 in a calendar year.

11. orthotics, when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist or chiropractor, limited to $750 in a 24 month period.
12. surgical dressings, pressure bandages and syringes furnished by a physician or surgeon in a doctor's office while the member was travelling outside of Canada.
13. elastic support stockings with a minimum compression of 20 mm or less and pressure gradient hose with a compression value of 20 mm to 40 mm, limited to a combined maximum of 4 pairs per calendar year.
14. stump socks, limited to 5 pairs per calendar year.

Exclusions

No benefit is payable for

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

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

To be insured for this benefit, you and your insured 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 insured 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, drugs or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your insured 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 insured dependant.

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.

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 (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 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 Sun Life or Sun Life's ETA provider, 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 insured dependant.

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

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 insured 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. Sun Life 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 reimburse 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 Sun Life's ETA provider, a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Sun Life's ETA provider will be able to provide you and your insured 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 card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Sun Life's ETA provider will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your insured dependant.
3. You will be required to sign an authorization form allowing Sun Life's ETA provider 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 Sun Life for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Sun Life's ETA provider 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 Sun Life's ETA provider 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 insured 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. Sun Life's ETA provider will hold such messages for 15 days.

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

Please consult the telephone numbers on your Travel card.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your insured 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 Insurance Provision.

If you are covered as a retired employee, you and your insured 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 Sun Life's ETA provider services in a particular country, please call the appropriate 24 hour helpline.

Neither Sun Life nor Sun Life's ETA provider is responsible for the availability, quality or results of the medical treatment received by you or your insured dependant, or for the failure to obtain medical treatment

Dental Insurance Provision

Benefit

This dental plan is a means to help you pay for your dental treatment. The services and procedures outlined in this booklet are not a treatment plan and should not determine the treatment and care decisions you and your dentist make. Your actual needs should determine these decisions

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

1. the deductible, which must be satisfied each year, is subtracted,
2. the reimbursement percentage is applied,
3. the maximums specified in the Summary of Insurance are applied, and
4. the general practitioners fee schedule is applied.

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

For each dental procedure, Sun Life will only cover up to the reasonable and customary charges.

Reasonable and customary charges mean

1. charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
2. charges of a reasonable frequency and duration, as determined by Sun Life.

In no case will the eligible expenses be more than the fee stated in the applicable Dental Association Fee Guide specified in the Summary of Insurance.

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

Co-ordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

Claims

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

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

If your dentist has recommended dental treatment that is expected to cost more than $500, or if your dentist has recommended dental treatment involving dentures, bridges or crowns, you may have your dentist prepare a pre-treatment plan that you can submit to Sun Life before you start treatment. For any other dental treatment, you can call Sun Life at 1 800 361-6212 to determine if the recommended dental treatment is eligible for payment.

Limitation period for Ontario:

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

Limitation period for any other province:

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

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act, or other similar legislation,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services performed by a person who is ordinarily a resident in the patient's home or who is closely related to the patient by blood or marriage,
- expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.
- 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 Insurance.

Dental Insurance Provision – Diagnostic/Preventive Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. examination and diagnosis:
   - oral examination (once every 6 months),
   - recall examination (once every 9 months for you and for your insured dependants 18 years of age and over; once every 6 months for your insured dependants under age 18),
   - limited periodontal examination (once every 6 months),
   - special oral examination,
   - treatment planning,
   - consultation,
   - house call, institutional call and office visit

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

c. radiographs:
   - complete series (once every 24 months),
   - periapical,
   - occlusal,
   - bitewing (once every 6 months),
   - extraoral,
   - sialography,
   - radiopaque dyes to demonstrate lesions,
   - temporomandibular joint,
   - panoramic (once every 24 months),
   - cephalometric film,
   - interpretation of radiographs received from another source,
   - tomography,

- hand and wrist (as diagnostic aid for dental treatment)

d. preventive services:
   - dental polishing (once every 9 months for you and for your insured dependants 18 years of age and over; once every 6 months for your insured dependants under age 18),
   - topical application of fluoride phosphate (once every 9 months for you and for your insured dependants 18 years of age and over; once every 6 months for your insured dependants under age 18),
   - oral hygiene instruction (once every 9 months for you and for your insured dependants 18 years of age and over; once every 6 months for your insured dependants under age 18),
   - pit and fissure sealants,
   - interproximal discing,
   - recontouring of teeth for functional reasons

e. space maintainers (insured dependent children only)

f. drug injections

g. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses for replacement of space maintainers which have been lost, stolen or mislaid,
4. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
5. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Restorative Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. restorations:
   - caries control,
   - trauma control,
   - amalgam,
   - acrylic or composite resin,
   - prefabricated restorations

b. periodontics:
   - non surgical services,
   - occlusal adjustment/equilibration,
   - scaling and root planning limited to 16 units per calendar year.

c. denture repairs and adjustments:
   - adjustment to dentures,
   - repairs/additions to dentures,
   - relining and rebasing of dentures

d. surgical services:
   - uncomplicated removals,
   - surgical removals and repositioning,
   - surgical excision,
   - surgical incision,
   - fractures,
   - frenectomy,
   - miscellaneous surgical services

e. anaesthesia (if performed in conjunction with oral surgery):
   - general anaesthesia,
   - deep sedation,
   - conscious sedation

f. laboratory procedures

g. implants, including surgery services:
   - crown and post, attachment to endosseous integrated implants
   - surgery on implants,
   - prosthodontic appliances on implants,

h. anaesthesia and drug injections in connection with implant surgery

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. charges for implants, and all related expenses, to replace a tooth or teeth removed before implants became an eligible expense under this benefit,
3. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
4. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
5. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Orthodontic Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. observation, adjustment:
   - oral examination,
   - skull and facial bone survey,
   - diagnostic cast,
   - surgical services,
   - observation, adjustment,
   - repairs, alterations,
   - active appliances for tooth guidance or uncomplicated tooth movement,
   - retention appliances

b. control of oral habits:
   - appliances,
   - adjustments, repairs, maintenance

c. comprehensive treatment

d. anaesthesia (if performed in conjunction with oral surgery):
   - general anaesthesia,
   - deep sedation,
   - conscious sedation

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for replacement of orthodontic appliances which have been lost, stolen or mislaid.
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Periodontic Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. periodontics:
   - surgical services,
   - post-surgical treatment,
   - adjunctive procedures,
   - post treatment evaluation

b. major surgery:
   - alveoloplasty,
   - enucleation of cyst,
   - dislocations

c. anaesthesia (if performed in conjunction with oral surgery):
   - general anaesthesia,
   - deep sedation,
   - conscious sedation

d. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement of periodontal appliances which have been lost, stolen or mislaid,
3. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Denture Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. partial and complete dentures:
   - complete dentures,
   - partial dentures

b. remakes partial dentures

c. examinations:
   - oral examination,
   - diagnostic casts

d. laboratory procedures

Replacement of an existing denture or bridgework with a denture, is an eligible expense if the replacement is required to replace an existing denture which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to an existing partial denture is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependant is insured under this benefit.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for initial dentures to replace a tooth or teeth missing before you or your insured dependant became insured under this benefit or to replace a tooth or teeth congenitally missing,
3. expenses for replacement dentures which have been lost, stolen or mislaid,
4. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
5. expenses for replacement of dentures and addition of teeth to existing dentures except as provided under Eligible Expenses,
6. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Bridge Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. fixed bridgework:
   - bridge pontics,
   - retainers,
   - other prosthetic services

b. repairs and adjustments:
   - porcelain repairs,
   - repairs to bridges

c. examinations:
   - oral examination,
   - diagnostic casts

d. laboratory procedures

Replacement of an existing denture or bridgework with bridgework is an eligible expense if the replacement is required to replace an existing denture or bridgework which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to existing bridgework is an eligible expense if the addition is required to replace one or more teeth removed while you or your insured dependant is insured under this benefit.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for initial bridgework (including crowns and inlays forming the retainers) to replace a tooth or teeth missing before you or your insured dependant became insured under this benefit or to replace a tooth or teeth congenitally missing,
3. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
4. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
5. expenses for replacement of bridgework and addition of teeth to existing bridgework except as provided under Eligible Expenses,
6. expenses for permanent splinting,

7. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
8. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Crown Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

a. crowns, inlays, onlays:
   - metal inlay restorations,
   - composite inlay restorations,
   - porcelain/ceramic inlay restorations,
   - crowns,
   - other restorative services

b. repairs and adjustments:
   - porcelain repairs,
   - recementing crowns

c. examinations:
   - oral examination,
   - diagnostic casts

d. laboratory procedures

Replacement of an existing crown, inlay or onlay is an eligible expense if the replacement is required to replace an existing crown, inlay or onlay which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original crown, inlay or onlay.

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while you or your insured dependant is insured under this benefit but are installed after termination of this benefit,
4. expenses for replacement of crowns, inlays or onlays except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Endodontic Benefit

Eligible Expenses

Eligible expenses mean REASONABLE AND CUSTOMARY charges for the following items of expense -

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

b. anaesthesia (if performed in conjunction with oral surgery):
   - general anaesthesia,
   - deep sedation,
   - conscious sedation

c. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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