

your **group**
benefits



Region of Waterloo

The Regional Municipality of Waterloo

Unifor Local 4304

**Group Policy No. 82000-900 and 901
Effective July 1, 2026
Issued June 12, 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. 82000-900 and 901

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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 in Human Resources and Citizen Service 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 email BenefitsHRC@regionofwaterloo.ca.

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 available from your benefits coordinator).

Summary of Insurance

Policy Number **82000-900 and 901**

Life Insurance

Class of Members	Benefit Formula	Maximum Benefit
T1. Full Time Employees	*2x Hourly Wage Rate x 2080	\$250,000
T10. Retirees who retired after January 1, 2009	**2x annual OMERS pension	\$250,000

***Amount of Benefit:** The amount of benefit is calculated by applying the benefit formula to the member's Hourly Wage Rate times 2080. This amount is rounded to the nearest \$500 if not already a multiple of \$500. It may not exceed the maximum benefit.

****Amount of Benefit:** The amount of benefit is calculated by applying the benefit formula to the member's annual OMERS Pension

Benefit Reduction (Class T1) – reduces to the lesser of 1 X earnings or \$50,000, at the end of the month following the member's 65th birthday

Termination of Insurance :

class T1 – end of the month following the member's 75th birthday, or retirement if earlier

class T10 - the end of the month following the member's 65th birthday

Long Term Disability Insurance

Class of Members	Benefit Formula	Maximum Monthly Benefit
T1. Full Time Employees	70% of Hourly Wage Rate x 2080 divided by 12	\$5,000
T10. Retirees who retired after January 1, 2009	--	--

Amount of Benefit: The amount of benefit is calculated by applying the benefit formula to the member's Hourly Wage Rate times 2080 divided by 12. This amount is rounded to the next higher \$5.00.

Monthly Disability Benefit

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

Your monthly disability benefit is the lesser of 1. and 2. below:

1. the benefit formula applied to your gross monthly earnings, limited to the maximum monthly benefit, less any disability and retirement income from:
 - a. the Canada/Quebec Pension Plan* or a similar pension plan, excluding benefits for dependent children.
 - b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
 - c. an automobile insurance policy.
 - d. 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 disability or retirement income.
2. 80% of your gross monthly earnings in force on the date you became totally disabled if the benefit is subject to income tax, or your net monthly earnings if the benefit is not subject to income tax, less any disability and retirement income from:
 - a. the Canada/Quebec Pension Plan* or a similar pension plan, excluding benefits for dependent children.
 - b. the Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
 - c. an automobile insurance policy.
 - d. another group insurance policy.
 - e. a retirement income plan providing income that becomes payable after you are no longer actively at work.
 - f. 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 disability or retirement income.

*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.

If your employer pays any portion of the Long Term Disability premium, your monthly disability benefit is subject to income tax.

If you pay 100% of the Long Term Disability premium, your monthly disability benefit is not subject to income tax.

Total Disability and Totally Disabled: mean that,

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

The medical impairment must be supported by objective medical evidence.

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

Qualifying Period : 17 weeks.

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 the end of the month following your 65th birthday.

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

Extended Health Insurance

Part	Benefit	Deductible		Reimbursement
		per person	per family unit	
A	Drug Benefit: Pay Direct*	\$10**	\$20**	100%
B	Vision: \$550***	none	none	100%
C	Hospital: semi-private	none	none	100%
D	Supp. Health Care	\$10**	\$20**	100%
E	Out-of-Province Emergency and Travel Assistance	none	none	100%

*The dispensing fee is limited to a maximum of \$10.00 per prescription.

**The deductible applies per calendar year. The deductible applies to the combined eligible expenses of Parts A and D.

***Maximum for eyeglasses/contact lenses/laser eye surgery in 24 consecutive months for you and for each insured dependant.

Termination of Insurance :

class T1 - end of the month following the member's 75th birthday, or retirement if earlier

class T10 - the end of the month following the member's 65th birthday

Dental Insurance

Part	Basic	Deductible per family unit	Reimbursement	Maximum
1	Basic*	none	100%	--
2	Denture	none	50%	\$1,000**
3	Orthodontic	none	50%	\$3,000***

4	Endodontic and Periodontic	none	100%	--
5	Denture Repairs	none	100%	--
6	Crowns	none	50%	\$1,000****
7	Surgical Removal	none	100%	--
8	Surgical Services and Drug	none	100%	--

*Dental recall examinations are limited to once every 6 months.

**The maximum amount payable applies to the eligible expenses incurred in a period of 5 calendar years under Part 2 for you and for each insured dependant.

***The maximum lifetime amount payable applies to the eligible expenses incurred under Part 3.

****The maximum amount payable applies to the eligible expenses incurred in a calendar year under Part 6.

Late Entrant Maximum: If an 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 T1 - end of the month following the member's 75th birthday, or retirement if earlier

class T10 - 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 Transit Services Unifor Local 4304.
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

- Life Insurance - nil
- Long Term Disability - the equivalent of 12 months of actual hours worked
- Extended Health and Dental - the first day of the month following the date of your employment

Eligibility for Retired Employees

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

1. He is a member immediately before his date of retirement.
2. He is a resident of Canada.

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 for 12 consecutive months.

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

If your new dependant is a common-law spouse, see your Plan Administrator to find out how to enrol for dependant 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 you are insured for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you will be insured for the similar coverage provided by 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. 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.

Long Term Disability Insurance Provision

Qualifying for Monthly Disability Benefits

You qualify for benefits when Sun Life receives proof that:

1. you are absent from active work because you are totally disabled,
2. you are totally disabled for as long as the qualifying period, and
3. 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 that physician,
4. you have satisfied the waiting period.

Your Monthly Disability Benefit

Your monthly disability benefit is calculated as shown on the Summary of Insurance at the front of this booklet.

Income to which you are entitled under a government plan will reduce your monthly disability benefit unless Sun Life receives proof that the initial application and an appeal, or a later re-application required by Sun Life, have been declined.

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

The total income you receive from all sources will not be less than your monthly disability benefit.

Your monthly disability benefit will not be reduced by any disability or retirement income you receive from the following sources:

1. a policy which is solely an individual disability income policy.
2. a disability attachment to an individual life insurance policy.
3. a retirement income plan providing income that becomes payable before you become totally disabled.

Rehabilitation

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

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

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

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

Example:

Assume you are earning \$2,000/month and have a 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 - 50% of Rehabilitation Income)
= \$1,000 + (\$1,400.00 - {50% of \$1,000})
= \$1,000 + \$900.00
= \$1,900.00

Since the benefit (\$1,900.00/month) does not exceed your pre-disability monthly earnings (\$2,000/month), there will be no reductions due to the 100% all source maximum.

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

Payment of Monthly Disability Benefit

The 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. Benefits are paid in arrears and will begin one month after you become eligible to receive them. You will receive one-thirtieth of the monthly disability benefit for each full day you are totally disabled following the qualifying period.

Benefits are payable from the latest of

- the end of the qualifying period,
- the date you are no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan, or
- the date you are no longer entitled to receive severance pay, payments in lieu of severance pay and damages, or settlements for wrongful dismissal.

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.

Survivor Benefit

If you die while receiving Long Term Disability Benefit payments, a survivor benefit will be paid to your designated beneficiary. The benefit is equal to 3 times your last monthly disability payment.

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

Exclusions and Limitations

No benefit is payable for a total disability due to or related to

- intentionally self-inflicted injuries,
- civil disorder or war, whether or not war was declared,
- committing or the attempt to commit an assault or criminal offence.

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

Extended Health Insurance Provision

Benefit

To qualify for the Extended Health coverage, you or your dependant must be entitled to benefits 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 12 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 31 days of the date of termination and this provision continues in force.

My Health CHOICE Coverage (Class T1)

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, including over-the-counter drugs.
2. injectible drugs.
3. compounded preparations, provided that the principal active ingredient is an eligible expense.
4. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
5. 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.
6. drugs for the treatment of smoke cessation that legally require a prescription are limited to a reimbursement of 50% and a lifetime maximum of \$350 for you and for each insured dependant.

Eligible expenses for drugs used for the treatment of obesity limited to a maximum of \$3,500 during the lifetime of you and each insured dependant.

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.

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 services, drugs and supplies which, in Sun Life's opinion, are experimental,
3. expenses for dietary supplements, vitamins and infant foods,
4. expenses for contraceptives (other than oral),
5. expenses for drugs which are used for cosmetic purposes,
6. expenses for drugs used for the treatment of sexual dysfunction,
7. drugs for the treatment of smoke cessation that do not legally require a prescription,
8. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
9. 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
10. 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. laser eye surgery, eye glasses, contact lenses and repairs to them that are necessary for the correction of vision and prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Insurance in any 24 consecutive months.
3. eyeglasses 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 expenses incurred within six months of each surgical procedure.

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:

1. 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.
2. room and board charges for ward accommodation for chronic care (not custodial care) provided in a licensed hospital. Confinement must be certified as medically necessary by a physician and is limited to \$3 per day and a lifetime maximum of 120 days.
3. room and board charges in a licensed private hospital in Canada, as prescribed by a physician, limited to a maximum of \$10 per day to a lifetime maximum of 120 days.

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

Acupuncturist

means a person licensed by the appropriate provincial licensing authority.

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.

Homeopath

means a person licensed by the appropriate provincial licensing authority as a homeopath, or a person who is an active member of a provincial homeopathic 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.

Psychotherapist

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

Psychologist

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

Reasonable and customary charges

mean those which are usually made to a person without 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 \$10,000 in a calendar year.
2. services of a massage therapist limited to a maximum of \$2,000 in a calendar year.
3. rental, or purchase at Sun Life's option, of medically necessary durable equipment that meets the patient's basic medical needs and is approved by Sun Life. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:
 - a. wheel chairs
 - b. wheel chair repairs, limited to a lifetime maximum of \$250,
 - c. walkers,
 - d. hospital beds,
 - e. traction kits,
4. trusses, crutches, braces, plaster of paris or fibreglass casts.
5. artificial limbs or eyes or other prosthetic appliances.
6. oxygen.
7. diagnostic laboratory and x-ray examinations.
8. wigs required as a result of chemotherapy or radiation therapy limited to a lifetime maximum of \$500 per person.

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9. 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.

10. surgical brassieres following a mastectomy, limited to a maximum of 6 surgical brassieres in a calendar year.
11. hearing aids and repairs to them, excluding batteries, limited to \$2,000 once every 24 months.
12. elastic support stockings with a minimum compression of 30mm limited to a maximum of 6 pairs per calendar year.

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

1. the services of the following practitioners, limited to a combined calendar year maximum of \$2,000.
 - an acupuncturist,
 - a chiropractor, including \$25 for one x-ray per calendar year,
 - a homeopath,
 - an osteopath, provided no portion of a charge for these services is payable under a government plan
 - a naturopath,
 - psychologist*, social worker*, psychotherapist*, clinical counsellor* or marriage or family therapist
 - a podiatrist or chiropodist, and
 - a speech language pathologist.

*If the combined maximum is reached in any calendar year, an additional combined maximum of \$500 will apply for the services of these practitioners only, for the remainder of the calendar year.

2. services of a physiotherapist.

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

3. licensed ground ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
4. orthopaedic shoes and orthopaedic modifications to shoes, when they are required for the correction of deformity of bones and muscles provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist or chiropractor, limited to a maximum of \$400 and one pair per calendar year.
5. 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 a maximum of \$400 per pair and 2 pairs per calendar year.

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6. 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 12 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident.

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 our 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 we have the right to deny or limit payments for all expenses related to that emergency.

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

Emergency Services Excluded from Coverage

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

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that we or 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 12 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 – Basic Benefit

Eligible Expenses

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

- a. examination and diagnosis:
 - oral examination (once every 3 years),
 - recall oral examination (once every 6 months),
 - special oral examination,
 - treatment planning,
 - consultation
 - with patient (maximum of 2 units every 12 months)
 - with member of the profession,
 - house call, institutional call and office visit
- b. tests and laboratory examinations:
 - microbiological test,
 - caries susceptibility test,
 - biopsy of oral tissue,
 - cytologic smear from oral cavity,
 - pulp vitality tests
- c. radiographs:
 - complete series (once every 3 years),
 - periapical, 1 to 15 films,
 - occlusal,
 - bitewing (once every 6 months),
 - extraoral,
 - sialography,
 - radiopaque dyes to demonstrate lesions,
 - temporomandibular joint,
 - panoramic (once every 3 years),
 - cephalometric film,
 - interpretation of radiographs received from another source,
 - tomography,
 - hand and wrist (as diagnostic aid for dental treatment)

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- d. preventive services:
 - dental polishing (once every 6 months),
 - topical application of fluoride,
 - oral hygiene instruction (once every 6 months),
 - caries control,
 - pit and fissure sealants on permanent molars only (once every 5 years),
 - interproximal discing of teeth,
 - recontouring to teeth for functional reasons,
 - occlusal adjustment/equilibration (8 units of time every 12 months)
 - e. restorations:
 - amalgam,
 - retentive pins,
 - acrylic or composite resin,
 - prefabricated restorations
 - f. anaesthesia
 - g. laboratory procedures

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 – Denture Benefit

Eligible Expenses

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

- a. diagnostic casts
- b. partial and complete dentures:
 - complete dentures (once every 5 years),
 - partial dentures (once every 5 years),
 - denture adjustments
- c. 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 – Orthodontic Benefit

Eligible Expenses

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

- a. miscellaneous services:
 - space maintainers,
 - diagnostic cast,
 - observation and adjustment
- b. active appliances for tooth guidance or uncomplicated tooth movement
- c. control of oral habits:
 - appliances to control oral habits,
 - myofunctional therapy,
 - repairs and maintenance
- d. retention appliances
- 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 – Endodontic and Periodontic Benefit

Eligible Expenses

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

- a. periodontics:
 - non surgical services,
 - surgical services,
 - post-surgical treatment,
 - scaling and root planing, (limited to 16 time units per year),
 - adjunctive procedures,
 - alveoloplasty
- b. endodontics:
 - pulpotomy,
 - root canal therapy,
 - periapical services,
 - other endodontic procedures,
 - emergency procedures
- c. laboratory procedures

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses for replacement of periodontal applications 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 Repair Benefit

Eligible Expenses

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

- a. repairs and adjustments:
 - adjustment to dentures (minor),
 - repairs/additions to dentures,
 - denture rebasing and relining,
 - remake dentures,
 - reset teeth
- b. 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.

Dental Insurance Provision – Crown Benefit

Eligible Expenses

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

- a. crowns, inlays, onlays (once every 3 years):
 - gold foil restorations,
 - inlay restorations,
 - onlay restorations,
 - crowns,
 - other restorative services,
- b. laboratory procedures

Dental Insurance Provision – Surgical Removal Benefit

Eligible Expenses

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

- a. surgical services:
 - uncomplicated removals,
 - surgical removals
- b. laboratory procedures

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.

Dental Insurance Provision – Surgical Services and Drug Benefit

Eligible Expenses

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

- a. surgical services:
 - surgical exposure, transplantation and repositioning,
 - surgical excision,
 - surgical incision,
 - fractures,
 - frenectomy,
 - miscellaneous surgical services
- b. adjunctive general services:
 - drugs (injections)
- c. laboratory procedures

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.

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