Sun Life Financial

your group benefits

# The Presbyterian Church In Canada

## Retired Employees – Outside Quebec

**Contract Number 50380**
**Effective July 1, 2024**

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# Benefit Details

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|---|---|
| Coverage | You are covered for:<br><br>Employee Life*<br>Accidental Death and Dismemberment*<br>Extended Health Care (Medicare Supplement)<br>Dental Care<br>*does not apply to employees Retired Age 70 |
| Eligibility requirements | You must:<br><br>■ be a resident of Canada, and<br><br>■ have been an active employee of the Church on the day preceding retirement. |
| Waiting period | None |

## EMPLOYEE LIFE

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| Amount | $10,000 |
| Termination | When you reach age 70 |

## ACCIDENTAL DEATH AND DISMEMBERMENT

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|---|---|
| Amount | Equal to your Life Coverage |
| Termination | When you reach age 70 |

## EXTENDED HEALTH CARE (MEDICARE SUPPLEMENT)

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| Benefit year | January 1 to December 31 |
| Deductible | None |
| Reimbursement level | |
| *In-province hospital* | 100% of the difference between the cost of a ward and a semi-private hospital room |
| *Convalescent hospital* | 100% up to $20 per day for a maximum of 120 days for all periods of treatment of an illness due to the same or related causes |
| *In-Canada expenses* | Emergency services – 100%<br>Referred services – 80% |
| *Prescription drugs* | 100% |
| *Medical services and equipment* | 100%<br>Private duty nurse lifetime maximum – $5,000 per person. This limit does not apply if you were receiving this benefit due to a disability that existed on or prior to December 31, 1990 |

| | |
|---|---|
| *Paramedical services* | 100% up to a maximum of:<br>For licensed physiotherapists – $500 per person per benefit year<br>For licensed speech therapists or massage therapists – $300 per person per benefit year per specialty<br>For licensed psychologists or social workers, clinical counsellors, family therapists, psychotherapists and psychoanalysis treatment – combined maximum of $1,500 per person per benefit year<br>For all other specialists – $500 per person per benefit year per specialty |
| *Hearing aids* | 100% up to a maximum of $250 per person over 2 benefit years |
| *Vision care* | 100% up to a maximum of $100 in any 12 month period for a person under age 18 or in any 24 month period for any other person |
| Maximum benefit | Lifetime maximum benefit – $50,000 per person. There is an automatic reinstatement each benefit year of up to $1,000 of benefits paid but not previously reinstated. This reinstatement will be made on the first day of each benefit year. |

## DENTAL CARE

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|---|---|
| Benefit year | January 1 to December 31 |
| Deductible | None |
| Reimbursement level | |
| *Preventive dental procedures* | 100% |
| *Basic dental procedures* | 100% |

| | |
|---|---|
| *Major dental procedures* | 50% |
| Fee guide | The current fee guide for general practitioners approved by the Dental Association in your province of residence, regardless of where the treatment is received<br><br>If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide approved by the provincial Dental Association for that specialist will be used<br><br>If services are provided by a dental assistant or dental mechanic, who is a member of a provincial group of Dental Assistants or Dental Mechanics which has its own fee guide, then the fee guide for the provincial group of Dental Assistants or Dental Mechanics will be used |
| Benefit year maximum | $2,000 per person |

# General Information

**Classes**

This booklet describes the coverage for the following classes of employees:

- Class 8 – Retired Employees – Outside Quebec
- Class 9 – Retired Age 70 – Outside Quebec

**About this booklet**

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

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

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

**Eligibility**

To be eligible for group benefits, the retirees must be a resident of Canada and an active employee of the Church.

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

**Who qualifies as your dependent**

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has

been publicly represented as your spouse for at least the last year, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 22.

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

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

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

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

### When coverage begins

Your coverage begins on the date you become eligible for coverage.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

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

Once you have dependent coverage, any subsequent dependents will be covered automatically.

### Updating your records

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

- change of dependents.
- change of name.
- change of beneficiary.

**Accessing your records**

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

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

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

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

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

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

**When coverage ends**

Your coverage will end on the earlier of the following dates:

- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the benefit provision under which you are covered terminates.

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

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.

- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

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

- 24 months after the date of your death.
- the date your spouse remarries.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

### Replacement coverage

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

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

### Making claims

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

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

All claims must be made in writing on forms approved by Sun Life.

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

**Legal actions**

Limitation period for Ontario:

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

Limitation period for any other province:

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

**Coordination of benefits**

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, our benefits will be coordinated with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

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

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

The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

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

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

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order applies:

  - the plan where the person is covered as an active full-time employee.
  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

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

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

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

**Recovering overpayments**

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

**Definitions**

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

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

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

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

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

# Extended Health Care
## (Medicare Supplement)

**General description of the coverage**

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

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

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

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

The benefit year is from January 1 to December 31.

**Deductible**

There is no deductible for this coverage.

**Lifetime maximum benefit**

Under Extended Health Care, the maximum amount we will pay for any person is $50,000. There is an automatic reinstatement each benefit year of up to $1,000 of benefits paid but not previously reinstated. This reinstatement will be made on the first day of each benefit year.

**Prescription drugs**

Drugs covered under this plan must have a Drug Identification Number

(DIN) and be approved under *Drug evaluation*.

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility, up to a lifetime maximum of $2,400 for each person.
- vaccines that legally require a prescription.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period as ordered by a doctor.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.

- products to help you quit smoking.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

***Drug evaluation***

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

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

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

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

***Dispensing fee***

Eligible expenses for the dispensing fee are limited to $9 for each prescription or refill.

***Drug substitution limit***

Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.

***Prior authorization program***

The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.

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

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

***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 covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered 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 covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

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

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

**Hospital expenses in your province**

We will cover 100% of the costs for hospital care in the province where you live.

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

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

The maximum amount payable is $20 per day up to a maximum of 120 days for treatment of an illness due to the same or related causes.

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

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

**Expenses in Canada**

We will cover emergency medical services while you are outside the province where you live, but in Canada. We will also cover referred services.

For both emergency services and referred services, we will cover the

cost of:

- a semi-private hospital room.
- out-patient services in a hospital.
- the services of a doctor.

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

***Emergency services***

We will pay 100% of the cost of covered emergency services.

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

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

An emergency ends when you are medically stable to return to the province where you live.

***Emergency services excluded from coverage***

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the

original emergency or any recurrence of it, after the date that Sun Life, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.

- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.

- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

***Referred services***

*Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 80% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and

- covered by the medicare plan in the province where you live.

**Medical services and equipment**

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

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a lifetime limit of $5,000 per person. The limit does not apply to anyone who was

receiving this benefit due to a disability that existed on or prior to December 31, 1990.

- transportation in a licensed ambulance if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, up to a maximum of $50 per person over 2 benefit years.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.

- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $400 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- artificial limbs and eyes, including replacements when medically necessary.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $250 per person over a period of 2 benefit years. Repairs are included in this maximum.
- radiotherapy, radiumtherapy, or coagulotherapy.
- oxygen, plasma, blood substitutes, and blood transfusions.
- Continuous Glucose Monitor (CGM), including receivers, transmitters, and sensors, for persons diagnosed with Type 1 or Type 2 diabetes requiring insulin use, up to a combined maximum of $4,000 per person per benefit year. You must provide us with a doctor's note confirming both the diagnosis and insulin use.

**Paramedical services**

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

- licensed physiotherapist, up to a maximum of $500 per person per benefit year.
- licensed massage therapists, when ordered by a doctor, up to a maximum of $300 per person in a benefit year.
- licensed speech therapists, up to a maximum of $300 per person in a benefit year.

- licensed dieticians, audiologists and occupational therapists, up to a maximum of $500 per person in a benefit year.
- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, podiatrists, chiropodists or naturopaths, including a maximum of one x-ray examination per specialty each benefit year, up to a maximum of $500 per person in a benefit year.

We will also cover 100% up to a combined maximum of $1,500 per person per benefit year for psychoanalysis treatment and all the qualified paramedical practitioners listed below:

- licensed psychologists or social workers.
- licensed psychotherapists, or psychotherapists who are active members of a provincial association approved by Sun Life.
- clinical counsellors who are active members of a provincial association approved by Sun Life.
- licensed family therapists, or family therapists who are active members of a provincial association approved by Sun Life.

We will cover, up to the limit specified above, the costs for psychoanalysis treatment when performed by a psychoanalyst who has undergone appropriate training and obtained the necessary credentials recognized by Sun Life.

**Contact lenses, eyeglasses or laser eye correction surgery**

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery. Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

We will cover 100% of these costs up to a maximum of $100 in any 12 month period for a person under age 18 or in any 24 month period for any other person.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction

of vision.

**What is not covered**

We will not pay for the costs of:

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

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

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

**Integration with**

This plan will integrate with benefits payable or available under the

**government programs**

government-sponsored plan or program (the *government program*).

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

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

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer.

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

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

# Dental Care

**General description of the coverage**

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

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

For each dental procedure, we will only cover reasonable and customary charges. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

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

If services are provided by a dental assistant or dental mechanic, who is a member of a provincial group of Dental Assistants or Dental Mechanics which has its own fee guide, then the fee guide for the provincial group of Dental Assistants or Dental Mechanics will be used.

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

*Reasonable and customary charges* mean:

- charges considered necessary for the treatment and maintenance of a person’s oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined by

Sun Life.

When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

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

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

The benefit year is from January 1 to December 31.

**Deductible**

There is no deductible for this coverage.

**Benefit year maximum**

We will not pay more than $2,000 per person for each benefit year for all services.

**Predetermination**

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

how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

## Preventive dental procedures

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

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

***Oral examinations***

1 complete examination every 24 months.

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

Emergency or specific examinations.

***X-rays***

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

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

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

***Other services***

Required consultations between two dentists.

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

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth, and habit-breaking appliances.

Pit and fissure sealants.

Oral hygiene instruction once every 5 months, up to a maximum of

2 sessions per benefit year.

Antibiotic medication and its administration when provided by injection by the attending dentist in his office.

**Basic dental procedures**

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

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

***Fillings*** Amalgam, composite, acrylic, silicate, or equivalent.

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

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

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

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

For scaling and root planing, up to a combined maximum of 4 units of 15 minutes per benefit year for a child under age 13 or 10 units of 15 minutes per benefit year for any other person.

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

***Repair*** Repair of bridges or dentures.

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

**Major dental procedures**

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

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

***Major restorations*** Inlays and onlays. Crowns and repairs to crowns, other than

prefabricated metal restorations (*Basic dental procedures*).

***Prosthodontics*** Construction and insertion of bridges or standard dentures. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

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

**What is not covered**

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

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

We will not pay for:

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

mouthguards.

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

We will also not pay for dental work resulting from:

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

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form.

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

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

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

# Life Coverage

**General description of the coverage**

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

**Life coverage for you**

***Amount***

Your Life benefit is $10,000.

***Coverage ends***

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

**Who we will pay**

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

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

**Converting Life coverage**

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

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

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

**When and how to make a claim**

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

# Accidental Death and Dismemberment

**General description of the coverage**

Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you die or suffer any of the losses listed in the table under *What we will pay*. Any death benefit paid under this coverage is in addition to the Life coverage.

**Accidental coverage for you**

***Amount***

Your Accidental Death and Dismemberment coverage is equal to the amount of Life coverage.

***Coverage ends***

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

**What we will pay**

We will pay for this benefit if you:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you are still alive.
- are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages we use to determine the payment.

## TABLE OF LOSSES

| | |
|---|---|
| Loss of life | 100% |
| Loss of both arms or both legs | 100% |
| Loss of both hands or both feet | 100% |
| Loss of one hand and one foot | 100% |
| Loss of one hand or one foot, and entire sight of one eye | 100% |
| Loss of one arm or one leg | 75% |
| Loss of one hand or one foot | 75% |
| Loss of four fingers on the same hand | 33 1/3% |
| Loss of thumb and index finger on the same hand | 33 1/3% |
| Loss of four toes on the same foot | 25% |
| Loss of use of both arms or both legs | 100% |
| Loss of use of both hands or both feet | 100% |
| Loss of use of one arm or one leg | 75% |
| Loss of use of one hand or one foot | 75% |
| Loss of entire sight of both eyes | 100% |
| Loss of speech and loss of hearing in both ears | 100% |
| Loss of entire sight of one eye | 75% |
| Loss of speech | 75% |
| Loss of hearing in both ears | 75% |
| Loss of hearing in one ear | 25% |
| Quadriplegia | 200% |
| Paraplegia | 200% |
| Hemiplegia | 200% |

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. We will not pay more than 100% of the amount of coverage if an accident results in more than one loss. This does not include quadriplegia, paraplegia or hemiplegia, where we will pay a maximum of 200%.

Loss of an arm means that it was severed at or above the elbow. Loss of a hand means that it was severed at or above the wrist. Loss of a leg means that it was severed at or above the knee. Loss of a foot means that it was severed at or above the ankle. Loss of a thumb, finger or toe means that it was severed at or above the first joint from the hand or foot. Loss of sight, speech or hearing must be total and permanent.

Loss of use must be total and must have continued for at least one year. Before we pay the benefit, you must provide proof that the loss is permanent.

**Limit on benefit amounts**

If more than one person covered by the group contract is eligible for benefits resulting from the same accident, Sun Life will pay up to a maximum of $3,000,000 for all claims related to the accident.

If the total amount of benefits payable for the accident is more than $3,000,000, then we will pay for each person a percentage of the $3,000,000 that is equal to the percentage the person would have received of the total payable.

**Repatriation benefit**

If you die as a direct result of an accident 100 kilometres or more from home, we will pay up to $10,000 for the preparation and transportation of the body for burial or cremation. We will pay the usual and reasonable expenses for this service. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

We may pay this benefit to any person who paid for the repatriation or has a claim for repatriation expenses against your estate. As long as this payment is made in good faith, Sun Life will be fully discharged to the extent of the payment.

**Rehabilitation program**

If you suffer a loss, other than a loss of life, we will pay up to $10,000 of your rehabilitation expenses. We will only pay for the usual and reasonable expenses connected with a rehabilitation program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the rehabilitation program and the expenses must be incurred within 3 years of the accident and while you are covered for this benefit. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the rehabilitation program will be based on the likelihood that it will be successful. The rehabilitation will be made up of training required, because of the loss, to prepare you for a new occupation.

**Spouse occupational training benefit**

If you die as a direct result of an accident, we will pay up to $5,000 to your spouse for occupational training. The training must be for a job that your spouse was not previously qualified for. We will only pay for the usual and reasonable expenses connected with an occupational training program. This does not include ordinary living expenses such as room, board, travelling or clothing.

We must approve the expenses and all expenses must be incurred within 3 years of the date of the accident. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Our approval of the training program will be based on the likelihood that it will be successful.

**Child education benefit**

If you die as a direct result of an accident, we will pay for a dependent child's tuition fees in a post-secondary school. We will pay the child 5% of the amount of coverage up to $5,000, each year up to a maximum of 4 years. The child must enrol as a full-time student within one year of your death.

We will only pay for the usual and reasonable tuition expenses. This does not include ordinary living expenses such as room, board, travelling or clothing. This also does not include education expenses incurred prior to your death.

**Family transportation benefit**

If you suffer a loss as a direct result of an accident and are hospitalized at least 150 kilometres from home, we will pay up to $5,000 for the usual and reasonable cost of hotel accommodations close to the hospital while you are hospitalized and for the travel expenses of an immediate family member. An immediate family member means a spouse, parent, child, brother or sister.

We will only pay for the usual and reasonable travel expenses. We will pay for car travel at a rate of $0.20 per kilometre. Transportation must be by the most direct route to and from the hospital. We will not pay for this service to the extent that it is reimbursed from other sources or covered under another benefit of this plan.

Any amount of coverage continued is subject to the terms of this group plan when total disability began.

**What is not covered**

We will not pay for losses that are the result of:

- self-inflicted injuries, by firearm or otherwise.
- a drug overdose.
- carbon monoxide inhalation.
- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- flying in, descending from or being exposed to any hazard related to an aircraft while
  - receiving flying lessons.
  - performing any duties in connection with the aircraft.
  - being flown for a parachute jump.
  - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- full-time service in the armed forces of any country.
- participation in a criminal offence, including when operating a motor vehicle with a blood alcohol content over the permissible level stipulated in the Criminal Code.

**Converting coverage**

If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy.

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

**When and how to make a claim**

For any loss other than death, the claim must be received by Sun Life within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your employer.

## 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.

## You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).