Sun Life Financial

your group benefits

OAKVILLE

The Corporation of the Town of Oakville

CUPE Local 1329 retirees

Contract Number 56261
Effective January 1, 2009

Published Date April 24, 2009

IMPORTANT INFORMATION

Benefit coverage based on Collective Agreement for the period February 16, 2007 to February 15, 2010.

Name:

Identification Number:

Personal Identification Number (PIN) or password _____ . This is used when telephoning to inquire about your claims history. Please note this is unique to you and should be kept confidential.

Sun Life Medical and Dental inquiries:

Toronto	(416) 753-4300
TOLL-FREE	1-800-361-6212
Fax Number	(416) 490-0224
Address	Sun Life of Canada Health Claims Office P O Box 4023 Station A Toronto ON M5W 2P7

Table of Contents

General Information

The information contained in this section applies only to benefits for which Sun Life of Canada is the insurer or plan administrator.

About this booklet

The information in this retiree 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 retiree benefits booklet, or you need additional information about your group benefits, please contact your employer.

The contract holder, The Corporation of the Town of Oakville, has the sole legal and financial liability for the following benefits:

- Extended Health Care
- Dental Care

Sun Life only acts as administrator on behalf of the contract holder for the above benefits. All other benefits are insured by Sun Life.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and must have been covered as an active employee immediately prior to retirement.

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 have 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.

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), if they are not married or in any other formal union recognized by law, are under age 21 and work less than 30 hours a week, unless they are a full-time student, are eligible dependents.

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

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

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

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

Enrolment

Enrolment must be at early retirement date if eligible. If you refuse coverage when eligible, you cannot enrol at a later date.

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.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exception applies if the result of the change is an increase in coverage:

- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

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

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

When coverage ends

As a retiree, 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 group contract ends.
- the last day of the month in which you attain age 65.

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 retiree benefits booklet.

Survivor benefits

If you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following dates:

- 12 months after the date of your death.
- 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.

The continuation of coverage does not apply to the Dental Care coverage.

Replacement coverage

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

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

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim. There are time limits for making claims. These limits are discussed in the appropriate sections of this retiree benefits booklet. All claims must be made in writing on forms approved by Sun Life.

No legal action may be brought by you more than one year after the date we receive your claim forms.

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical examination

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.

Recovering overpayments

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

Definitions

Here is a list of definitions of some terms that appear in this retiree 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)

Plan administrator

This benefit is administered by Sun Life of Canada.

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the retiree 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.

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

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

The deductible is the portion of claims that you are responsible for paying.

The deductible for prescription drugs is the portion of any dispensing fee over $8 for each prescription or refill.

For other expenses, there is no deductible.

Lifetime maximum benefit

For out of province and out of Canada emergency, the maximum amount we will pay for any person is $1,000,000. For out of province referrals, the maximum amount we will pay for any person is $50,000. Under Extended Health Care, for all other expenses, the maximum amount we will pay for any person is $1,000,000. Amounts you received as an active employee are included in this maximum.

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

We will cover 100% of the cost of drugs and supplies that are prescribed in writing by a doctor or dentist and are obtained from a pharmacist.

For the following expenses you should use your drug card:

- medication listed in the Federal or Provincial Drug Schedules which has a Drug Identification Number (DIN) and requires a prescription.
- injectable drugs, insulin and allergy extracts with a DIN.
- preparations and compounds of which at least one ingredient is an eligible drug under this benefit.
- diabetic supplies, including lancets.
- products to help a person quit smoking that require a prescription, up to a lifetime maximum of $500 for each person.
- drugs for the treatment of infertility up to a lifetime maximum of $2,500 for each person.

For the following expenses you must submit a claim to Sun Life for reimbursement:

- compound serums that require a prescription.
- intrauterine devices (IUDs), diaphragms.

- colostomy supplies.
- varicose vein injections, if medically necessary.

For the above items, payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period, or, in the case of the following maintenance drugs, in a 100 day period as ordered by a doctor:

antiasthmatics, antibiotics for acne, anticoagulants, anticonvulsants, antihypertensives, antiparkinsons, antituberculosis, cardiac agents, hypoglycaemic, medications for glaucoma, estrogen, oral contraceptives, potassium replacements and thyroid agents.

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

- vaccines.
- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatment.
- the cost of giving injections, serums and vaccines.
- medicines obtained from a doctor or dentist.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- muscle relaxants which do not require a prescription.
- hair growth stimulants.
- products to help you quit smoking that do not require a prescription.
- drugs for the treatment of erectile dysfunction.
- Norplant.

Generic limit

Charges in excess of the lowest priced equivalent generic product are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

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 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 follows at least 3 consecutive days of in-patient hospitalization,
- it begins within 14 days of release from the hospital, and
- it is primarily for rehabilitation.

The maximum amount payable is $20 per day up to a maximum of 180 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 out of your province

We will cover emergency services while you are outside the province where you live. We will also cover referred services.

For both emergency services and referred services, we will cover the cost of:

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

Expenses for all other services 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.

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

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

the province where the person lives.

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Emergency services excluded from coverage

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

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

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Emergency services out of your province

Expenses incurred for emergency services outside the province where you live are subject to a lifetime maximum of $1,000,000 per person or, if lower, any other applicable lifetime maximum. Amounts you received as an active employee are included in this maximum.

Referred services out of your province

Expenses incurred for referred services outside the province where you live are subject to a lifetime maximum of $50,000 per person or, if lower, any other applicable lifetime maximum. Amounts you received as an active employee are included in this maximum.

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). Contact Sun Life for confirmation regarding eligibility and frequency. It is recommended that an estimate be submitted for expenses greater than $200.

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $10,000 per person per benefit year.

- 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. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province.*

- transportation in a licensed air ambulance if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- laboratory tests performed by a commercial laboratory for the diagnosis of an illness. Tests performed in a doctor's office or pharmacy are not covered.

- 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 retiree 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.
- wigs following chemotherapy or Alopecia Totalis, up to a maximum of $400 per person in any 24 month period with a doctors referral.
- custom made supports.
- equipment rented, or purchased at our request, that is for temporary therapeutic use. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical bras up to a maximum of 2 per person in a benefit year.
- artificial limbs and eyes, excluding myoelectric appliances.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $350 per person in any 12 month period.
- 1 pair of custom-made orthopaedic shoes (excluding modifications to orthopaedic shoes) when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $500 per person in any 12 month

period.

- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per person over a period of 4 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of $700 per person.

Paramedical services

We will cover 100% of the costs for the following paramedical specialists, up to the maximums indicated below:

- licensed speech therapists, psychologists, acupuncturists or massage therapists, when ordered by a doctor – maximum of $400 per person in a benefit year for each category of paramedical specialists.
- licensed osteopaths or osteopathic practitioners, chiropractors, podiatrists, chiropodists, or naturopaths including a maximum of one x-ray examination per specialty each benefit year – maximum of $400 per person in a benefit year for each category of paramedical specialists. The costs of x-ray examinations are not included in the benefit year maximum.
- licensed physiotherapists or athletic therapists, when ordered by a doctor – combined maximum of $600 per person in a benefit year.

We will not pay for the cost of services rendered by a podiatrist in Ontario unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

Vision care

We will cover the costs for:

- contact lenses or eyeglasses, including replacement lenses and/or frames and tinting of lenses, prescribed by an ophthalmologist or

licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician.

- services of an ophthalmologist or licensed optometrist.
- laser eye correction surgery performed by an ophthalmologist.

We will cover 100% of these costs up to a maximum of $350 in any 24 month period per person.

We will also cover the cost of contact lenses for special conditions such as severe corneal astigmatism, severe corneal scarring, keratoconus (conical cornea), aphakia or when acuity in the better eye cannot be improved to at least 20/40 with glasses, up to a lifetime maximum of $600 for each 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.

When coverage ends

Extended Health Care coverage will end on the last day of the month in which the retiree reaches age 65.

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

Payments after coverage ends

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, as if the benefit were still in effect.

What is not covered

We will not pay for the costs of:

- services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees and extra billing if the legislation allows private plans to cover the user fees and extra billing.

- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.

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.

We will also not pay benefits when compensation is available under a Workplace Safety Insurance Board, Criminal Injuries Compensation Act or similar legislation.

When and how to make a claim

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

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.

Emergency Travel Assistance

Plan administrator

This benefit is insured by Sun Life of Canada.

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (*Europ Assistance*) can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Europ Assistance. If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact

could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Europ Assistance may arrange for:

On the spot medical assistance

Europ Assistance will provide referrals to physicians, pharmacists and medical facilities.

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Europ Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel.

Europ Assistance will transmit an urgent message from you to your home, business or other location. Europ Assistance will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

Europ Assistance will arrange and, if necessary, advance funds for transportation to the province where you live:

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

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

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

Travel expenses of family members

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

- you are travelling alone, or

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and Europ Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Europ Assistance will ask you to sign a form authorizing them to act on your behalf.

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association.

The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Europ Assistance:

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

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

Limits on Emergency Travel Assistance coverage

There are countries where Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.

Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

- a rebellion, riot, military up-rising, war, labour disturbance, strike,

nuclear accident or an act of God.

- the refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Europ Assistance

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

Dental Care

Plan administrator

This benefit is administered by Sun Life of Canada.

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the retiree 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 expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the retiree lives which was current one year prior to the date the eligible expenses were incurred, regardless of where the treatment is received.

Services provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality are limited to the amount payable under the Fee Guide for general practitioners.

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 usual and reasonable 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:

- $2,750 per person for each benefit year for Preventive and Basic dental procedures combined.
- for Major dental procedures:
  - $1,000 per person for each benefit year for procedures related to dentures.
  - $1,500 per person for each benefit year for all other Major dental procedures.

Lifetime maximum

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

This maximum includes amounts you received as an active employee.

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 $200. 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 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 36 months.

1 recall examination every 9 months.

Emergency or specific examinations.

X-rays 1 complete series of x-rays or 1 panorex every 36 months.

1 set of bitewing x-rays every 9 months.

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

Other services Required consultations with another dentist.

Polishing (cleaning of teeth) once every 9 months.

Topical fluoride treatment once every 9 months, for children under the age of 18.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once per lifetime.

Basic dental procedures Your dental benefits include procedures used to treat basic dental problems. Some examples are filling cavities and extracting teeth.

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

Fillings Amalgam, composite, acrylic or equivalent.

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

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

Endodontics Root canal therapy and root canal fillings, treatment of disease of the pulp tissue and chemical bleaching of teeth.

Periodontics Treatment of disease of the gum and other supporting tissue, excluding temporomandibular joint (TMJ) treatment.

Occlusal equilibration, 8 units every 12 months.

Scaling and root planing **Tartar removal.** Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

You are covered for up to 8 units of 15 minutes of tartar removal in a benefit year.

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

Major dental procedures

Your dental benefits include procedures used to treat major dental problems. Some examples are crowns, dentures or bridges.

We will pay 100% 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*). Porcelain crowns on molar teeth and porcelain bridges on molar teeth are also covered.

Repair Repair of bridges or dentures.

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

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 needed to replace a bridge or denture due to an accidental injury.

Other services Diagnostic casts.

Orthodontic procedures

Your dental benefits include procedures used to treat misaligned or crooked teeth. Only persons age 6 or over are covered for these procedures.

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

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

The following orthodontic procedures are covered:

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

When coverage ends Dental Care coverage will end on the last day of the month in which the retiree reaches age 65.

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

Payments after coverage ends

If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees and extra billing if the legislation allows private plans to cover the user fees and extra billing.

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.
- 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).

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.
- teeth malformed at birth or during development.
- participation in a criminal offence.

We will also not pay benefits when compensation is available under a Workplace Safety Insurance Board, Criminal Injuries Compensation Act or similar legislation.

When and how to make a claim

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

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

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 $2,000.

Coverage ends

Your coverage will end on the last day of the month in which you reach age 65. 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.

Converting Life coverage

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

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

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

When and how to make a claim

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

Respecting Your Privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.