

your **group**
benefits



OAKVILLE

The Corporation of the Town of Oakville

Retired firefighters

**Contract Number 56261
Effective October 1, 2018**

Published Date March 22, 2019

IMPORTANT INFORMATION

Benefit coverage based on Collective Agreement for period January 1, 2018 to December 31, 2022.

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

Sun Life Financial Plan Member Services website at www.mysunlife.ca

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Company of Canada
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Table of Contents

General Information	1
About this booklet.....	1
Eligibility	1
Who qualifies as your dependent	2
Enrolment.....	2
When coverage begins	3
Changes affecting your coverage	3
Updating your records.....	3
Accessing your records	4
When coverage ends	4
Continuation of coverage for spouses age 60 to 65	5
Surviving dependent coverage	5
Replacement coverage	6
Making claims.....	6
Legal actions for insured benefits	6
Legal actions for self-insured benefits	7
Coordination of benefits.....	7
Medical examination	9
Recovering overpayments	9
Definitions.....	9
Extended Health Care (Medicare Supplement)	10
General description of the coverage.....	10
Deductible	10
Prescription drugs	10
Hospital expenses in your province	14
Expenses out of your province.....	15
Medical services and equipment	17
Paramedical services	19
Vision care	20
When coverage ends	21
Payments after coverage ends	21
What is not covered.....	21
Integration with government programs	22
When and how to make a claim	23

Emergency Travel Assistance24

Dental Care.....30
General description of the coverage.....30
Deductible31
Benefit year maximum31
Lifetime maximum.....31
Lifetime maximum.....31
Predetermination31
Preventive dental procedures31
Basic dental procedures32
Major dental procedures.....33
Orthodontic procedures.....34
When coverage ends34
Payments after coverage ends34
What is not covered.....34
When and how to make a claim36

Life Coverage.....37
General description of the coverage.....37
Life coverage for you37
Who we will pay37
Converting Life coverage.....38
When and how to make a claim38

General Information

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, self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care

This means that The Corporation of the Town of Oakville plays a role similar to that of an insurance company for its employees. The Corporation of the Town of Oakville has the sole legal and financial liability for the benefits listed above and funds the claims from its net income, retained earnings or other financial resources. Sun Life provides administrative services only (ASO) such as claims processing. 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, 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.

Normally, you request coverage for yourself or your dependents within 31 days of becoming eligible for coverage. If you do not request coverage within this time limit, you will have to provide proof of good health at your own expense.

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.

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

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.

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.

Continuation of coverage for spouses age 60 to 65

If your coverage ends because you attain age 65, coverage for your spouse can continue until your spouse reaches 65. The continuation of coverage includes Extended Health Care and Dental Care, other than orthodontic procedures.

Surviving dependent coverage

If you die while covered by this plan, coverage for your dependents will continue until the earlier of the following dates:

- when you have a spouse:
 - the date the spouse becomes eligible for coverage under another group plan.
 - the date your spouse reaches age 65.
 - the end of the period for which premiums have been paid for spouse coverage.
 - the date the benefit provision under which the spouse is covered terminates.

Coverage for your spouse will continue, without premium payment for the first 6 months after the date of your death. After this time, your spouse may elect to continue coverage with premium payment.

- where there is no spouse, benefits will continue for dependent children, without payment of premiums, until the earlier of the following dates:
 - the date the dependent child reaches age 21.
 - the date the dependent child becomes eligible for coverage under another group plan.

- the date the benefit provision under which the dependent child 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.

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 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 for insured benefits

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.

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the 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.

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)

General description of the coverage	<p>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.</p> <p>In this section, <i>you</i> means the retiree and all dependents covered for Extended Health Care benefits.</p> <p>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 <i>Prior authorization program</i> for details).</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>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.</p> <p>The benefit year is from January 1 to December 31.</p>
Deductible	<p>The deductible is the portion of claims that you are responsible for paying.</p> <p>The deductible for prescription drugs is the portion of any dispensing fee over \$16 for each prescription or refill.</p> <p>For other expenses, there is a deductible of \$10 each benefit year for each person up to a maximum of \$20 per family. After this deductible has been paid, claims will be paid up to the percentage of coverage under this plan.</p>
Prescription drugs	<p>Drugs covered under this plan must have a Drug Identification Number</p>

(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, including over-the-counter drugs.
- injectable drugs and vitamins.
- oral vitamins and mineral supplements.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$500 for each person.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.
- muscle relaxants. You will be required to provide a pharmacy receipt including the product name and DIN number, the cost, the patient's name and the date the medication was dispensed.

We will cover 100% of the cost of the above drugs and supplies after you pay the deductible.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, 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), proteins 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.
- drugs for the treatment of infertility.
- 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.

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

***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, after you pay the deductible.

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 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 without a deductible.

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, AZGA Service Canada Inc. (*Allianz Global Assistance*). All invasive and investigative

procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global 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 Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global 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 Allianz Global 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 100% of the costs of referred services without a deductible. 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 maximum of \$1,000,000 per person per occurrence 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 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 limit of \$25,000 per person during any 3 consecutive benefit years.

- 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.
- prostate specific antigen (PSA) tests performed by a commercial laboratory.
- 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 6 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.
- equipment rented, or purchased at our request, that is for temporary therapeutic use.
- casts, splints, trusses, braces or crutches.
- custom made back supports.

-
- artificial limbs and eyes, excluding myoelectric appliances.
 - elastic support stockings, including pressure gradient hose, up to a maximum of 1 pair per person in a benefit year.
 - wigs following chemotherapy or radiation therapy, when ordered by a doctor, up to a maximum of \$500 per person in a benefit year.
 - 1 pair of custom-made orthopaedic shoes or custom-made orthotic inserts for shoes every benefit year, when prescribed by a doctor, podiatrist or chiropodist.
 - hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$2,500, including batteries and ear moulds when necessary as part of the hearing aid device, per person every 36 months. 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 \$350 per person.

Paramedical services

For each category of paramedical specialists listed below we will cover:

- 100% of the costs, after you pay the deductible, for licensed speech therapists, when ordered by a doctor, up to a maximum of 50 visits per person each benefit year.
- 100% of the costs, after you pay the deductible, for licensed naturopaths up to a maximum of \$500 per person each benefit year.
- 100% of the costs, after you pay the deductible, up to a maximum of \$500 per person each benefit year for the services of licensed osteopaths or osteopathic practitioners in addition to a maximum of one x-ray examination per person each benefit year.

- 100% of the costs, after you pay the deductible, for licensed chiropractors to a maximum of \$800 per person each benefit year. In addition, a maximum of \$100 will be payable for x-ray examinations per person each benefit year.
- 100% of the costs, after you pay the deductible, for licensed physiotherapists or occupational therapists.
- 100% of the costs, after you pay the deductible, for licensed massage therapists, when ordered by a doctor up to a maximum of \$1,200 (*\$1,300 effective January 1, 2020, \$1,400 effective January 1, 2021, \$1,500 effective January 1, 2022*) in a benefit year for the employee and spouse only.
- 100% of the costs, after you pay the deductible, for licensed psychologist, licensed psychotherapists or psychotherapists who are active members of a provincial association approved by Sun Life, when ordered by a doctor, up to a maximum of \$3,000 each benefit year per person.
- 100% of the costs, after you pay the deductible, for licensed athletic therapists up to a maximum of \$800 in a benefit year for the employee and spouse only.

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, tinting of lenses, and prescription sunglasses, prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician.
- laser eye correction surgery performed by an ophthalmologist.

We will cover 100% of these costs, without a deductible, up to a maximum of \$650 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 \$525 for each person.

We will also cover 100% of the costs for services of an ophthalmologist or licensed optometrist, up to a maximum of \$80 in any 24 month period per person.

We will not pay for magnifying glasses, or safety glasses of any kind.

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 you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

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 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 customary 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.
- 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.

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

Integration with government programs

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

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

- whether you 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.

Emergency Travel Assistance

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 employee 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, AZGA Service Canada Inc. (*Allianz Global 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 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.

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 Allianz Global Assistance. If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global 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.

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

As soon as Allianz Global Assistance is notified that you have a medical emergency, its staff, or a physician designated by Allianz Global 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, Allianz Global Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

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

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

Transportation home or to a different medical facility

Allianz Global 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, Allianz Global Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Based on medical factors, a physician designated by Allianz Global Assistance 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, Allianz Global 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.

Allianz Global 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 Allianz Global 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

Allianz Global 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, Allianz Global 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

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

Vehicle return

Allianz Global 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, Allianz Global 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

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 Allianz Global 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 Allianz Global 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 Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure.

Allianz Global 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 Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

Allianz Global Assistance will not provide services in the province where you live, or during any trip taken for the purpose of seeking medical attention.

**Liability of Sun Life
or Allianz Global
Assistance**

Neither Sun Life nor Allianz Global 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

**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 employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time 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	For Major dental procedures, we will not pay more than: <ul style="list-style-type: none"> ■ \$2,000 per person for each benefit year for procedures related to dentures, and ■ \$3,500 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 \$3,500.
Lifetime maximum	The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is \$4,000.
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 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.
<i>Oral examinations</i>	1 complete examination every 36 months. 1 recall examination every 9 months. Emergency or specific examinations.
<i>X-rays</i>	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 any person under age 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 the following procedures used to treat basic dental problems.

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, and treatment of disease of the pulp tissue and chemical bleaching.

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 per person 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 the following procedures used to treat major dental problems.

Of the eligible expenses, we will pay:

- 50% for procedures related to dentures, and
- 100% for all other procedures.

Major restorations

Inlays and onlays. Crowns (including porcelain crowns on molars) and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).

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 (including porcelain bridges on molars) 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,

extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.

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.

We will not pay benefits when compensation is available under a Workers' Compensation Act, Criminal Injuries 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

General description of the coverage	Your Life coverage provides a benefit for your beneficiary if you die while covered.
Life coverage for you	
<i>Amount</i>	Your Life benefit is \$5,000.
<i>Coverage ends</i>	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 <i>General Information</i> .
Who we will pay	<p>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.</p> <p>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.</p> <p>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.</p>

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

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit www.sunlife.ca/privacy.

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).

