

District School Board of Niagara

Elementary School Teachers

*Group Plan No. 83620
Group Plan No. 25456
(Division 2)*

your **group**
benefits

Your Group Benefits Booklet

Keep in a safe place

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

Your Plan Administrator is there to help

Your plan administrator can:

- help you enrol in the plan
- provide you with the forms you need to claim group benefits
- answer any questions you may have

Benefits and claims information at your fingertips

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

We're on the Internet!

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

Our address is:

www.sunlife.ca

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 to obtain information about our privacy practices, 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.

The statements in this booklet are only a summary of some of the provisions in the master policy. If you need further details on the provisions which apply to your group benefits you must refer to the master policy (available from your plan administrator).

Summary of Insurance

Policy Number 83620-2 - Life Insurance

Basic Life Insurance

Class of Members	Benefit Formula	Maximum Benefit
2. Elementary School Teachers	--	\$60,000

Termination of Insurance: the end of the month in which you turn 70 or retire, whichever is earlier

Optional Life Insurance

Class of Members	Benefit Formula
2. Elementary Teachers	Units of \$10,000 The minimum benefit is \$20,000 The maximum benefit is \$250,000

Termination of Insurance: 65th birthday, or retirement if earlier

Optional Spousal Life Insurance

Class of Members	Benefit Formula
Spouse	Units of \$10,000 The minimum benefit is \$20,000 The maximum benefit is \$250,000

Termination of Insurance: the earlier of the member's 65th birthday, retirement, or the spouse's 65th birthday

Optional Dependant Life Insurance

Option 1

Spouse: \$20,000

Each Child: \$10,000

Option 2

Spouse: \$40,000

Each Child: \$20,000

Termination of Insurance: the end of the month in which you turn 70 or retire, whichever is earlier

Summary of Benefits

Plan Number 25456-2 – Health and Dental Benefits

Extended Health

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Drug: Pay Direct	none*	100%	none
B	Vision: \$250**	none	100%	none
C	Hospital: ward to semi-private (Optional)	none	100%	none
D	Supp. Health Care	none	100%	none
	Note: reimbursement for the following Paramedical services: - registered massage therapist - speech language pathologist, - Chiropractor, - osteopath, - naturopath, - podiatrist or chiropodist	none	90%	See page Q-2 for further information
E	Out-of-Province Emergency and Travel Assistance	none	100%	\$1,000,000***

*Dispensing fees are capped at \$8.00 per prescription.

**Maximum for eyeglasses/contact lenses and laser eye surgery every 24 month period for you and for each covered dependant. (12 months for a covered dependant under age 18.)

***The maximum lifetime amount payable applies to the eligible expenses incurred under Part E for you and for each covered dependant.

Termination Age: the end of the month in which you turn 70 or retire, whichever is earlier

Dental

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Basic Services	none	100%	none
B	Endodontic and Periodontic	none	100%	none
C	Denture Repairs	none	100%	none
D	Dentures	none	70%	none
E	Crowns and Bridges	none	70%	none
F	Orthodontic Services	none	50%	\$3,000*

*The maximum lifetime amount payable applies to the eligible expenses incurred under Part F for you and for each covered dependant.

Termination Age: the end of the month in which you turn 70 or retire, whichever is earlier

Dental Fee Guide: The applicable fee guide is the fee guide in effect one year before the prevailing fee guide in the province where the expense is incurred, or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, the prevailing fee guide is the 1997 Alberta Fee Guide plus an annual inflationary adjustment determined by us. The fee guide will be updated by one year on each January 1st.

General Information

Eligibility

You are eligible, and continue to be eligible, to be a member while you meet all of the following conditions:

1. You are regularly working for District School Board of Niagara under an approved contract on a permanent basis.
2. You are a resident of Canada.

Participation is compulsory, with the exception of Optional Life Insurance.

If you are on a Board approved leave of absence, you are eligible, and continue to be eligible to be a member for all benefits except Long Term Disability provided you were regularly working for District School Board of Niagara under an approved contract on a permanent basis just before the leave began and you are a resident of Canada.

You are eligible, and continue to be eligible, for dependant coverage while you meet all of the following conditions:

1. You are a member.
2. You have at least one dependant.
3. Your dependants are residents of Canada.

Definitions

Dependant

means your spouse or a dependent child of you or your spouse. If Sun Life does not approve evidence of insurability required for a dependant, the dependant will not be a covered dependant.

Dependent child

means a natural, adopted or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on you for maintenance and support and who is

1. under 21 years of age,
2. under 25 years of age and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

Spouse

means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship for 12 consecutive months, or your former spouse from whom you are separated or divorced.

Only one person at a time can be covered as your spouse under this plan.

Enrolment

To enrol for Optional Life Insurance you must submit a completed enrolment form. Evidence of insurability is also required, except for 3 units of insurance if the request for insurance is made within 31 days after the date you become eligible.

To enrol for Optional Spousal Life Insurance you must submit a completed enrolment form and evidence of insurability for your spouse to Sun Life.

To enrol for all other coverage, you must submit a completed enrolment form.

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

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

If your new dependant is a common-law spouse, see the Human Resources Department to find out how to enrol for dependant coverage.

Effective Date

Your Optional Life Insurance is effective on the later of the date that you become eligible or the date that Sun Life approves any evidence of insurability.

You become eligible for all other coverage on the date you become eligible.

Your dependant coverage is effective on the latest of

- the date that you become eligible for dependant coverage,
- the date that you request dependant coverage, or
- the date that Sun Life determines the insurability of all of your dependants and approves at least one dependant.

If you are absent from work on the date your insurance or your dependant coverage would be effective, then that coverage will not be effective until the date you return to active work.

Changes in Coverage

If you request an increase in the amount of Optional Life Insurance, you must submit evidence of insurability to Sun Life. The increase in the amount of insurance will be effective on the date that Sun Life approves the evidence of insurability.

An increase in your benefits, the amount of your coverage or the amount of your dependant coverage due to change in your group benefit plans design or a change in your classification becomes effective on the date of the change, unless you are not actively working on that day due to disease or injury.

If, due to disease or injury, you are not actively working on the date an increase in your benefits, the amount of your coverage or the amount of your dependant coverage would be effective, the increase becomes effective on the date you return to active work. Sun Life may require evidence of insurability to establish the date that you are physically and mentally fit to return to active work. If so, the increase becomes effective on the date Sun Life establishes. If Sun Life doesn't approve the evidence of insurability required, the increase will not be effective.

Comparable Coverage

If you are covered for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you may request the similar coverage offered under this plan.

If your dependant is covered for comparable coverage under another plan, you may decline the dependant coverage for the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops, you may request the similar coverage offered under this plan.

The coverage that replaces the comparable coverage is effective on the date that the comparable coverage stops.

Termination of Coverage

Your coverage could terminate for a number of reasons. For example,

- you are no longer eligible, (i.e. you are no longer actively working),
- you reach the Termination Age,
- the provision or the policy terminates.

Basic and Optional Member Life Insurance Provision

Benefit

The amount of benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or if the beneficiary has predeceased you, payment will be made to your estate.

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

If you become totally disabled before age 65, your Life Insurance may be continued. Premiums for the continued insurance will be waived after you have been totally disabled from the same or related causes for six continuous months.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. The claimant must submit proof of the claim and the right to receive the benefit to Sun Life.

If you become totally disabled, you must submit a disability claim to Sun Life after you have been totally disabled continuously for 6 months but not beyond 12 months after the date you became totally disabled.

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

Death Benefit - Exclusion

No benefit is payable for any amount of Optional Life Insurance that has been in force for less than 2 years if death is due to suicide while sane or insane.

At Termination

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

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

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

Optional Dependant Life Insurance Provision

Benefit

The amount of benefit will be paid to you upon the death of your insured dependant.

For Optional Spouse Life Insurance, if you have appointed a beneficiary, the amount of benefit will be paid to the beneficiary upon the death of your insured spouse.

If you become totally disabled, your Dependant Life Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Claims

A claim must be received by Sun Life within 6 years of the date of death. You must submit proof of claim and the right to receive the benefit to Sun Life.

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

Exclusion

No benefit is payable for an insured dependant who dies before reaching the age of 24 hours.

No benefit is payable for any amount of Optional Dependant Life Insurance that has been in force for less than 2 years if death is due to suicide, while sane or insane.

At Termination

If your Dependant Life Insurance for your spouse terminates due to the termination of your Member Life Insurance, your spouse may convert the amount of the dependant insurance terminated to an individual policy on his life.

Your spouse must apply and pay the premium to Sun Life within 31 days after termination of insurance.

Where necessary in order to comply with applicable legislation: If the dependant insurance for a child terminates due to the termination of your insurance, you may convert the amount of the dependant insurance terminated to an individual policy on the child's life without submitting evidence of insurability.

The conditions that apply to the Conversion Privilege for the member's insurance will apply to the Conversion Privilege for the dependant insurance.

If your Dependant Life Insurance terminates and the dependant dies within 31 days after termination of insurance, we will pay you the amount of insurance which could have been converted to an individual policy on the dependant life's through the Conversion Privilege of this provision, or the amount stipulated in any applicable legislation, if greater.

Extended Health Provision

Benefit

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. To determine the amount payable, the total amount of eligible expenses you claim will be adjusted as follows:

1. the maximums described throughout the extended health benefit provisions are applied,
2. then the deductible, which must be satisfied each calendar year, is subtracted, and
3. the reimbursement percentage is applied.

Example:

Assume that your plan has a \$25 deductible and a reimbursement level of 80%. The maximum that your plan covers for eyeglasses is \$250 every 24 month period. You have submitted an eyeglass claim for \$200. This is the first extended health claim you have submitted this year so the deductible does need to be paid by you.

To determine the amount that you would be refunded for this claim:

1. The maximum eligible amount under the plan is \$250. Therefore, the amount of the claim that will be considered for payment is \$250.
2. The \$25 deductible is applied to the submitted amount of \$200. The amount has now been reduced to \$175.
3. The reimbursement level is 80%. This means that 80% of the remaining \$175 will be refunded to you. 80% of \$175 is \$140. \$140 will be paid to you for this eyeglass claim.
4. The maximum eligible amount under the plan is \$250. \$250 less the \$200 that you submitted for this eyeglass claim is \$50. This means that \$50 will still be considered for payment for other eyeglass expenses during this 24 month period.

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

Co-ordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

Claims

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

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

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

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to intentionally self-inflicted injuries,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
- expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with Government Programs*,
- expenses for benefits which are legally prohibited by the government from coverage,
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

Integration with Government Programs

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

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

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

At Termination

If, on the date of termination of your coverage,

- you have a medically determinable physical or mental impairment due to injury or disease which prevents you from performing the regular duties of the occupation in which you participated just before the impairment started, regardless of the availability of work for you, or
- your covered dependant has a medically determinable physical or mental impairment due to injury or disease, is receiving treatment from a physician and is confined to a hospital or his home,

benefits will be payable for eligible expenses related to the impairment provided they are incurred within 90 days of the date of termination and this provision continues in force.

If you die, your covered dependant's Extended Health Benefits will be continued for 3 months, as long as the Extended Health provision remains in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

My Health CHOICE Coverage

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

To be eligible, you must:

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

My Health CHOICE coverage may also include Dental coverage if you had both Extended Health and Dental Benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependants if those family members were covered under your group plan.

If you have any questions about this product, please call our Customer Solutions Centre at 1-877-893-9893 Monday to Friday, 8:00 am to 8:00 pm EST.

Extended Health - Pay Direct Drug Benefit

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.
6. oral and non-oral contraceptives.

To claim for expenses for vaccines and preventative inoculations, the member must submit the receipts directly to Sun Life.

Prior Authorization Program

The prior authorization (PA) program applies to a limited number of drugs taken for non-life-threatening conditions 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 Sun Life's PA form to submit this information. Both you and your doctor need to complete parts of the form.

You will be covered for these drugs if the information you and your doctor provide meets Sun Life's medical criteria. If not, your claim will be declined. For most drugs in the program, there is an alternate drug available to treat the illness, which may be covered under this plan.

Processing of the PA form takes 2 business days from the time the PA form is received. You will be contacted either directly or through your pharmacy (as per your request on the PA form) once a decision is made. Sun Life keeps approval information on file so that you can submit future claims for the drug at the pharmacy using your drug card.

A limited number of drugs in the following categories are included in the PA program:

1. muscle or nerve disorder drugs.

The list of drugs within each category will change from time to time as drugs are added or removed. Please contact your benefits administrator for the most current list.

Sun Life's prior authorization forms are available from the following sources:

1. Sun Life Financial Plan Member Services website at www.mysunlife.ca
– from there, click on *Group Benefits* and then *Prior Authorization Drug List and Forms*
2. Sun Life Financial Customer Care centre
– call toll-free 1-800-361-6212
3. your employer
– ask your benefits administrator

Drug Substitution Limit

The maximum amount payable for an eligible drug will be limited to the lowest priced drug in the appropriate category, unless the physician or dentist has indicated no substitution on the prescription form.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your covered dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. the yearly or per prescription deductible on drugs that are eligible under the Ontario Drug Benefit plan and are purchased by you or your covered spouse who is age 65 or over,
3. expenses for drugs which, in Sun Life's opinion, are experimental,
4. expenses for dietary supplements, vitamins and infant foods,
5. expenses for drugs which are used for cosmetic purposes,
6. expenses for drugs used for the treatment of sexual dysfunction,
7. expenses for smoking cessation aids,
8. expenses for drugs used for the treatment of infertility,
9. expenses for drugs used for the treatment of obesity,
10. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
11. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
12. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health - Vision Benefit

Definitions

Laser Eye Surgery

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

Ophthalmologist

means a person licensed to practise ophthalmology.

Optometrist

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

Reasonable and customary charges

mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

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

1. eye examinations by an optometrist limited to one examination in a 24 month period (12 month period for an covered dependant under age 18).
2. laser eye surgery, eyeglasses and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Benefits.
3. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to a lifetime maximum of \$200 for the non-surgical treatment of keratoconus for you and each covered dependant and a maximum of \$200 for each surgical procedure.

Exclusion

No benefit is payable for

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

Preferred Vision Services (PVS)

Preferred Vision Services Inc. (PVS) is a network of more than 1,000 healthcare service providers across the country. The PVS program offers discounts on the purchase of prescription eyewear, hearing aids and even laser eye surgery through preferred providers registered in the PVS network. As long as you are covered under this group benefits plan, you and your dependants are eligible for the PVS discount program.

Read more about the PVS program and how to obtain savings on your purchases in our PVS brochure. The brochure also includes a PVS card to take with you when you visit a PVS provider. A copy of the brochure is available from your plan administrator or when you sign into our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

New providers and services are being added to the network all the time. To find out what services are available and for the PVS locations nearest you, call the PVS information centre toll-free number 1-800-668-6444, or visit the PVS website at www.pvs.ca.

Extended Health - Hospital Benefit

Definitions

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

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

Exclusion

No benefit is payable for

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

Extended Health - Supplementary Health Care Benefit

Definitions

Chiropodist, Podiatrist

means a person licensed by the appropriate provincial licensing authority.

Chiropractor

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

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Naturopath

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

Osteopath

means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association or a person who holds a Diploma in Osteopathic Manual Practice (DOMP) and is recognized by the Ontario Association of Osteopaths.

Physiotherapist

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

Psychologist

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

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Massage Therapist

means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications we determine to be comparable with those required by a licensing body.

Registered Nurse

means a nurse who is listed on the appropriate provincial registry.

Speech Language Pathologist

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

Eligible Expenses

To be eligible, the following expenses must be medically necessary for the treatment of disease or injury.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of the following practitioners, limited to a calendar year maximum of \$500 for each practitioner, reimbursed at 90%. (example: \$500 x 90% = \$450).
 - a. a registered massage therapist,
 - b. a speech language pathologist,
 - c. a chiropractor,
 - d. a naturopath,
 - e. a podiatrist, or chiropodist,
 - f. an osteopath.

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

2. one x-ray examination by a chiropractor limited to \$15 per calendar year.
3. one x-ray examination by an osteopath limited to \$15 per calendar year.
4. one x-ray examination by a podiatrist limited to \$15 per calendar year.
5. the services of a psychologist limited to a calendar year maximum of \$1,200.
6. the services of a physiotherapist.
7. visual therapy.

To be eligible, the following expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician. Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.) when provided in the patient's home limited to a calendar year maximum of \$25,000. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N.
2. the services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 12 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident. A physician's prescription is not required.
3. licensed ground ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
4. emergency air ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.
5. orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist or chiropractor.
6. hearing aids and repairs to them, excluding batteries.
7. trusses and crutches, including custom made stockings or elastic support stockings with a compression of 30mm.
8. braces, provided they are not solely for athletic use.
9. artificial limbs or other prosthetic appliances.
10. oxygen and blood.
11. diagnostic laboratory and x-ray examinations.
12. wigs, as a result of chemotherapy.
13. rental, or purchase at our option, of durable equipment which is required for temporary therapeutic use in the patient's home and is approved by Sun Life. Eligible durable equipment includes, but is not limited to, items such as:
 - a. wheel chairs,
 - b. wheel chair repairs, limited to a lifetime maximum of \$250,
 - c. walkers,
 - d. hospital beds,
 - e. traction kits.
14. room and board and normal nursing care in a licensed nursing home or chronic hospital for the ward user fee up to \$10 per day and limited to a lifetime maximum of 120 days provided the provincial hospital plan pays a portion of the ward rate.

15. The following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence.
1. public ward accommodation and auxiliary hospital services in a general hospital limited to, after deducting the amount payable by a government plan, \$75 a day for 60 days in a calendar year.
 2. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

Items of expense incurred outside Canada are eligible only if they are not offered in any province in Canada.

Exclusions

No benefit is payable for

1. expenses for the services of a registered nursing assistant (R.N.A.), licensed practical nurse (L.P.N.) or homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the use of a service,
5. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

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

To be covered for this benefit, you and your covered dependant must have provincial health care coverage. Expenses for hospital/medical services and travel assistance benefits are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside your home province,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 60 days of travelling on vacation or business outside your home province. Your 60 days of coverage starts on the day you or your covered dependant departs from your home province.

Definitions

Emergency

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

Emergency services

mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your covered dependant have a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Family member

means you or your covered dependant.

Reasonable and customary charges

mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Relative

means your spouse, parent, child, brother or sister.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact Sun Life's Emergency Travel Assistance 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 we have the right to deny or limit payments for all expenses related to that emergency.

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

Emergency Services Excluded from Coverage

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

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.

3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that we or Europ Assistance, based on available medical evidence, determines that the family member can be returned to his province of residence, and he refuses to return.
4. services which are required for the same illness or injury for which the family member received emergency services, including any complications arising out of that illness or injury, if the family member had unreasonably refused or neglected to receive the recommended medical services.
5. where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Eligible Expenses for Hospital/Medical Services

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services, less the amount payable by a government plan:

1. public ward accommodation and auxiliary hospital services in a general hospital,
2. services of a physician,
3. economy air fare for the patient's return to his province of residence for medical treatment,
4. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation,
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

The maximum lifetime amount payable for the above Eligible Expenses is \$1,000,000 for you and for each covered dependant.

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

Eligible Expenses for Travel Assistance Benefits

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services:

1. family assistance benefits, which include reimbursement for the cost of:
 - a. return transportation for covered dependent children who are under the age of 16, or who are handicapped, if they are left unattended because you or your spouse is hospitalized outside your province of residence. We will arrange the transportation of the dependent child to your home, and if necessary, an escort will be provided to accompany him. The maximum payable for the return transportation is a one-way economy fare for each dependent child.
 - b. return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
 - c. visit of one relative, if a family member is hospitalized for more than 7 days while travelling without a relative. This includes meals and accommodation up to a maximum of \$150 per day, and round-trip economy transportation, for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of his body.
 - d. meals and accommodation up to a maximum of \$150 per day per family, if a trip is extended because a family member is hospitalized.

The combined maximum amount payable for the above family assistance benefits is \$5,000 for one travel emergency.

2. return of a deceased family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. The maximum amount payable for the preparation and return of the deceased is \$5,000. Preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased **includes** a basic shipping container, but **excludes** expenses for burial, such as burial caskets and urns.

3. return of a vehicle. If a family member is unable to operate a vehicle (owned or rented) because he is being returned to Canada for medical treatment, Sun Life will administer reimbursement of the cost of returning this vehicle to his province of residence, or the nearest appropriate rental agency. This benefit is also payable in the event of a family member's death. The maximum amount payable for returning the vehicle is \$1,000.

Travel Assistance Services

Out-of-province and around-the-world services are provided through Europ Assistance USA, Inc., a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Europ Assistance will be able to provide you and your covered dependants with the following emergency assistance services during the first 60 days of travel:

1. physician and hospital referrals,
2. on-going monitoring of medical treatment if a family member is hospitalized,
3. coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer him to another hospital that is equipped to provide the required treatment,
4. payment assistance for hospital/medical expenses,
5. legal referrals,
6. a telephone interpretation service,
7. a message service for you, your family, friends and business associates.

Emergency Payment Assistance

Eligible Hospital/Medical Expenses:

To ensure payment of these expenses,

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Sun Life travel assistance card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Europ Assistance will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your covered dependant.
3. You will be required to sign an authorization form allowing Europ Assistance to recover any amounts payable by the provincial health care plan.
4. For expenses that require a percentage paid by you, or that are not covered under this plan or the provincial health care plan, you must reimburse us for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Europ Assistance and they will coordinate payments with the provincial health care plan and Sun Life.

24 Hour Helpline

If emergency assistance is needed, a 24 hour helpline is available. Multilingual coordinators at Europ Assistance can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The 24 hour helpline can assist you and your covered dependant if you have lost your passport or visa, if you need to find a local legal advisor, or if you require telephone interpretation services. You can also call the helpline and leave important messages for family, friends or business associates; likewise, they can call the helpline and leave messages for you while you travel. Europ Assistance will hold such messages for 15 days.

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

Please consult the telephone numbers on your travel assistance card.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your covered dependant due to an emergency which occurs more than 60 days after departure from your province of residence,
2. expenses incurred on a non-emergency or referral basis,
3. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Provision.

If you are covered as a retired employee, you and your covered dependants must return to your province of residence for at least 30 consecutive days before becoming eligible for another 60 days of coverage.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries. For more information on travelling conditions and the availability of Europ Assistance services in a particular country, please call the appropriate 24 hour helpline.

Neither we nor Europ Assistance is responsible for the availability, quality or results of the medical treatment received by the family member, or for the failure to obtain medical treatment.

Dental Provision

Benefit

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

1. the deductible, which must be satisfied each year, is subtracted,
2. the reimbursement percentage is applied, and
3. the maximums specified in the Summary of Benefits are applied.

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

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

Co-ordination of Benefits

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

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

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

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

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

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

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

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

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

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

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

4. the plan of the spouse of the parent not having custody of the dependent child.

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

Claims

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

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

If your dentist has recommended dental treatment that is expected to cost more than \$500, you must have your dentist prepare a pre-treatment plan.

There is a time limit for proceedings against Sun Life for payment of a claim. A proceeding must be started within 1 year of Sun Life's receipt of the proof of claim.

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation,
- expenses incurred due to intentionally self-inflicted injuries,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for which benefits are payable under a government plan.

At Termination

If you die, your covered dependant's Dental Benefits will be continued for 3 months without payment of premiums as long as the Dental provision remains in force. Your dependants must contact your Plan Administrator to arrange the extension of coverage.

Dental Provision - Basic Services

Eligible Expenses

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

- a. examination and diagnosis:
 - oral examination (once every 5 years),
 - recall oral examination (once every 9 months),
 - special oral examination,
 - treatment planning,
 - consultation,
 - house call, institutional call and office visit
- b. tests and laboratory examinations:
 - microbiologic culture,
 - caries susceptibility tests
 - biopsy of oral tissue,
 - cytologic smear from oral cavity,
 - pulp vitality tests,
- c. radiographs:
 - periapical (one complete series every 3 years),
 - periapical, one to ten films,
 - occlusal,
 - bitewing (once every 18 months),
 - extra oral,
 - sialography,
 - radiopaque dyes to demonstrate lesions,
 - temporomandibular joint,
 - panoramic (once every 3 years),
 - cephalometric film,
 - interpretation of radiographs received from another source,
 - tomography,
 - hand and wrist (as diagnostic aid for dental treatment)
- d. preventive services:
 - dental polishing (once every 9 months),
 - topical application of fluoride (once every 9 months for children under age 19),
 - pit and fissure sealant (for persons under 19 years of age),
 - caries control,
 - interproximal discing of teeth,
 - recontouring to teeth for functional reasons
 - occlusal equilibration (8 units of time every 12 months)
- e. restorations:
 - amalgam,
 - retentive pins,
 - acrylic or composite resin,
 - stainless steel crowns
- f. anaesthesia
- g. in office laboratory procedures

Dental Provision - Endodontic and Periodontic Services

Eligible Expenses

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

- a. periodontics:
 - non surgical services,
 - surgical services including surgical services related to implants,
 - post-surgical treatment,
 - scaling and root planning,
 - adjunctive procedures,
 - alveoplasty
- b. endodontics:
 - pulpotomy,
 - root canal therapy,
 - periapical services,
 - other endodontic procedures,
 - gingival curettage, alveolectomy, banding of tooth,
 - hemisection,
 - canal and/or pulp enlargement,
 - chemical bleaching only (per unit of time),
 - intentional removal, apical filling and reimplantation,
 - emergency procedures
- c. surgical services other than implant related surgery:
 - uncomplicated removals,
 - surgical removals,
 - surgical exposure, transplantation and repositioning,
 - surgical excision,
 - surgical incision,
 - fractures,
 - lacerations,
 - frenectomy,
 - miscellaneous surgical services
 - reconstruction, alveolar ridge
- d. adjunctive general services:
 - drugs (injections)
- e. in office laboratory procedures

Dental Provision - Denture Repairs

Eligible Expenses

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

- a. repairs and adjustments:
 - adjustment to dentures,
 - repairs/additions to dentures,
 - denture rebasing and relining
- b. in office laboratory procedures

Dental Provision - Dentures

Eligible Expenses

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

- a. partial and complete dentures:
 - complete dentures (once every 3 years),
 - partial dentures (once every 3 years)
- b. examinations:
 - oral examination
- c. laboratory procedures

Dental Provision - Crowns and Bridges

Eligible Expenses

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

- a. crowns, inlays, onlays:
 - gold foil restorations,
 - inlay restorations,
 - porcelain restorations,
 - crowns,
 - other restorative services
- b. fixed bridgework:
 - bridge pontics,
 - repairs to bridges,
 - retainers,
 - other prosthetic services
- c. implants, including surgery charges other than periodontal surgery, subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant. For the implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively.
- d. in office laboratory procedures
- e. examinations:
 - oral examinations

Dental Provision - Orthodontic Services

Eligible Expenses

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

- a. miscellaneous services:
 - space maintainers
 - diagnostic cast
 - observation and adjustment
 - oral examination
- b. active appliances for tooth guidance or uncomplicated tooth movement
- c. appliances to control harmful habits:
 - myofunctional therapy
- d. retention appliances
- e. in office laboratory procedures