Sun Life Financial

your group benefits

Peel Regional Police Services Board

Retired Officers, Senior Civilians and Senior Officers
(Uniform and Civilian Senior Managers)

(Class 8A)

Group Plan No. 150420
Effective January 1, 2021
Issued December 21, 2020

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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 contracts with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies, as described below. 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.

The contract holder, Peel Regional Police Services Board, has entered into an Administrative Services Contract with Sun Life for the following benefits:

- Extended Health
- Dental

The contract holder has the sole legal and financial liability for these benefits and Sun Life only acts as administrator.

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

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

General Information

Eligibility

As a retired employee you are eligible, and continue to be eligible, to be a member while he meets all of the following conditions:

1. You are a member immediately before your date of retirement.
2. You are a resident of Canada.

Waiting Period – nil

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, he 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 22 years of age,
2. under 25 years of age and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

He, his and him
refer to both genders.

Spouse
means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship for at least one year. There can only be one spouse covered under the plan at one time

Enrolment

If you have a dependant, request dependant coverage when you enrol.

If you request dependant coverage more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life.

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

If your new dependant is a common-law spouse, see your Plan Administrator to find out how to enrol for dependant coverage.

For late entrants, evidence of insurability submitted to Sun Life is at your expense.

Effective Date

Your coverage is effective on the date of your retirement.

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.

Changes in Coverage

An increase in your benefits, the amount of your coverage or the amount of your dependant coverage due to change in your group benefit plan's design or a change in your classification becomes effective on the date of the change.

If Sun Life doesn't approve an increase in the amount of your coverage or the amount of your dependant coverage, any future increase in the maximum benefit amount will not be effective unless evidence of insurability is approved. An increase in the maximum benefit amount will be effective on the date Sun Life approves the evidence of insurability.

Termination of Coverage

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

- you reach the Termination Age,
- the provision or the policy terminates.

Summary of Benefits

Plan Number *150420*

Extended Health

Part	Benefit	Deductible per family unit	Reimbursement
A	Drug: Pay Direct*	none	100%
B	Vision: $150**	none	100%
C	Hospital: ward to semi-private	none	100%
D	Supp. Health Care	none	100%
E	Out-of-Province Emergency and Travel Assistance	none	100%

*The maximum amount payable for the dispensing fee is limited to $6.50 per prescription.

**Maximum for eyeglasses/contact lenses and laser eye surgery every 24 month period for you and for each covered dependant.

Termination Age: none

Dental

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Basic	none	100%	--
D	Periodontic and Endodontic	none	100%	--
E	Denture Repair	none	100%	--
G	Surgical Removal	none	100%	--
H	Surgical Services and Drug	none	100%	--

Termination Age: none

Dental Fee Guide: The applicable fee guide is the one in force for general practitioners on the day when and 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, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide for general practitioners plus an inflationary adjustment determined by Sun Life.

Extended Health Provision

Benefit

To qualify for the Extended Health coverage, you or your dependant must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

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

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, and
2. the reimbursement percentage is applied.

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 before the end of the calendar year following the year 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.

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 Sun Life 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.

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services 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 services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

Integration with Government Programs

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

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

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

At Termination

If, on the date of termination of your 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,

The hospital benefit 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. All other benefits will be payable for eligible expenses related to the impairment provided they are incurred within 365 days of the de of termination and this provision continues in force.

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) and be approved under *Drug evaluation*. There are additional eligibility requirements that apply, see *Prior authorization program* for details.

1. drugs which legally require a prescription
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs (including radioisotope material)
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. hepatitis A vaccine and hepatitis B vaccine
7. drugs used for the treatment of infertility limited to $5,000 per member in a calendar year

Drug evaluation

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

1. drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
2. 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 Sun Life's approval.

Sun Life 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 condition(s).
- plan sustainability.

Drug Substitution Limit

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

Prior Authorization Program

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

In order for drugs in the PA program to be covered, the covered person needs to provide medical information using Sun Life's PA form. Both the covered person and the attending physician need to complete parts of the form.

The covered person will be eligible for coverage for these drugs if the information provided by the covered person and the attending physician meets Sun Life’s 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.
- the covered person’s response to preferred drug therapy.

If not, the claim will be declined.

The prior authorization forms are available from the following sources:

1. Sun Life's website at www.mysunlife.ca/priorauthorization
2. Sun Life's Customer Care centre by calling toll-free 1-800-361-6212

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 a member or his covered spouse who is age 65 or over,
3. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
4. expenses for drugs which, in Sun Life's opinion, are experimental,
5. expenses for dietary supplements, vitamins and infant foods (except vitamins used in the treatment of multiple sclerosis),
6. expenses for contraceptives (other than oral),
7. expenses for drugs which are used for cosmetic purposes,
8. expenses for drugs used for the treatment of sexual dysfunction,
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

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 ophthalmologist or optometrist limited to one examination in a 24 month period (12 month period for a covered dependant under age 22).
2. eyeglasses, contact lenses and repairs to them and laser eye surgery when necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Benefits for eligible expenses incurred during a 24 month period for you and for each covered dependant.
3. contact lenses certified by an ophthalmologist as necessary due to severe corneal stigmatism, corneal scarring, keratoconus or aphakia provided visual acuity can be improved to at least 20/40 by contact lenses but cannot be improved by that level by eyeglasses, limited to $200 during a 24 month period for the member and for each covered dependant.
4. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to cataract surgery or for persons who lack organic lenses, limited to once in a lifetime for the member and for each covered dependant.
5. services for the visual training and remedial exercises

Exclusion

No benefit is payable for

1. expenses for non-prescription sunglasses, or safety glasses to be used during the course of employment
2. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Hospital Benefit

Definitions

Chronic or convalescent hospital

means a legally licensed hospital with beds or units designated for convalescent or chronic care and which provides facilities for diagnosis, care and treatment of a person suffering from disease or injury on a 24 hour basis, with 24 hour services by registered nurses and physicians. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care

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.

Licensed nursing home

means an institution other than a hospital where registered nursing care is provided and where the province pays a daily allowance for the confinement. Homes for the aged, retirement or rest homes or other premises or places providing similar care and are excluded, except that a chronic care section of a hospital or a convalescent hospital providing specialized treatment of convalescing or chronically ill person will be included if charges for such treatment are not paid for by the province

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

1. accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.
2. semi-private accommodation in a public chronic care hospital or a chronic wing facility of a hospital, limited to $3 per day for a period of 120 days,
3. out patient charges, excluding professional fees.

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

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.

Qualified

means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body the person must be an active member of an association approved by Sun Life.

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.

Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant, Licensed Practical Nurse, Registered Practical Nurse

means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or bodily 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.), registered nursing assistant (R.N.A.), certified nursing assistant (C.N.A.), licensed practical nurse (L.P.N.) when provided in the patient's home, limited to a maximum of $25,000 in a calendar year. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A. or L.P.N. A pre-determination of services must be submitted and approved by Sun Life prior to the service being commenced. Payment for these services exclude the charges in excess of the fee level set by the largest nursing registry of Ontario and agency fees, commissions or overtime fees.

2. the services of the following qualified practitioners, limited to a maximum of $30 per visit and a calendar year maximum of $300 for each qualified practitioner.
   a. a physiotherapist*,
   b. a psychologist*,
   c. a chiropractor*, plus up to $30 for one x-ray examination per calendar year.

   *physician's prescription not required.

   Where applicable, expenses for practitioners' services eligible under a provincial health care plan will be reimbursed before expenses exceed the annual maximums under the provincial plan, starting from the first visit to the practitioner.
3. the services of the following qualified practitioners, limited to a maximum of $30 per visit and a calendar year maximum of $300 for each qualified practitioner.
   a. a massage therapist*,
   b. an osteopath*, plus up to $30 for one x-ray examination per calendar year
   c. a podiatrist* or chiropodist*, plus up to a calendar year maximum of $100 for the surgical removal of nails or plantar warts
   d. a naturopath*

   *physician's prescription not required

4. The services of a qualified speech language pathologist, limited to $30 per visit to a calendar year maximum of $300.
5. the services of a dentist or 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 6 months of the accident and the services are performed while the patient is covered under this plan.
6. licensed ground ambulance service or any other vehicle normally used for public transportation, to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
7. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
8. Pressure gradient hose*, orthopaedic shoes, orthopaedic modifications to shoes, and orthopaedic shoes which are attached to and form part of a brace, provided they are not solely for athletic use and are prescribed by a physician, limited to a combined maximum of $500 in a calendar year. *Pressure gradient hose, will be restricted to two pairs per calendar year and 50% of the cost of the hose.
9. orthotics, provided they are not solely for athletic use and are prescribed by a physician, limited to a maximum of $350 per calendar year.
10. hearing aids and repairs to them, excluding batteries, limited to a maximum of $300 per 3 calendar year period.
11. trusses and crutches.
12. plaster of paris or fibreglass casts.
13. braces, provided they are not solely for athletic use.

14. splints, cervical collars
15. artificial limbs, eyes or other prosthetic appliances.
16. oxygen.
17. blood products, therapeutic radiation
18. diagnostic laboratory and x-ray examinations.
19. internal catheters, urinary kits, external breast prostheses (following mastectomies)
20. ostomy supplies (where a surgical stoma exists)
21. rental, or purchase at our option, of medically necessary durable equipment that meets the patient's basic medical needs and is approved by Sun Life. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:
    a. respirator,
    b. iron lung,
    c. wheel chairs,
    d. wheel chair repairs,
    e. walkers,
    f. hospital beds,
    g. traction kits.
22. the following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence.
    a. public ward accommodation and auxiliary hospital services in a general hospital limited to, after deducting the amount payable by a government plan, the level of services in the patient's province of residence
    b. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

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

Exclusions

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the use of a service,
5. expenses for brain or body scanners, or those in connection with cosmetic or plastic surgery unless for restorative purposes to repair tissue damaged by disease or bodily injury

6. expenses for eye glasses or hearing aids, except as otherwise provided in this agreement, rest cures, travel for health reasons, periodic health check-ups or examinations or examinations for coverage purposes
7. expense for services provided in a health spa, chronic care or psychiatric hospital, chronic care unit of a general hospital, or for the services or supplies provided while confined in a nursing home or home for the aged, when the covered member is in receipt of provincial government assistance, except as otherwise provided in this provision.
8. expenses for vaporizers or nebulizers.
9. 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, 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 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 Allianz Global 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 Allianz Global Assistance, a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Allianz Global 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 card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Allianz Global 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 Allianz Global 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 Allianz Global 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 Allianz Global 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. Allianz Global 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 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 Allianz Global Assistance services in a particular country, please call the appropriate 24 hour helpline.

Neither we nor Allianz Global 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

This dental plan is a means to help you to pay for your dental treatment. The services and procedures outlined in this booklet are not a treatment plan and should not determine the treatment and care decisions you and your dentist make. Your actual needs should determine these decisions.

You will be reimbursed when you submit proof to Sun Life that you or your 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 calendar 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 by the end of the calendar year following the year 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 or other necessary information may be required.

If your dentist has recommended dental treatment that is expected to cost more than $500, or if your dentist has recommended dental treatment involving dentures, bridges or crowns, you may have your dentist prepare a pre-treatment plan that you can submit to Sun Life before you start treatment. For any other dental treatment, you can call Sun Life at 1 800 361-6212 to determine if the recommended dental treatment is eligible for payment.

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 Sun Life 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.

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 a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services performed by a person who is ordinarily a resident in the patient’s home or who is closely related to the patient by blood or marriage,

- expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with. Laboratory charges are also limited to 66 2/3% of the fee for the procedure in the Dental Fee Guide shown on the Summary of Benefits.

Dental Insurance Provision – Basic Benefit

Eligible Expenses

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

a. examination and diagnosis:
   - oral examination (once every 3years),
   - recall oral examination (once every 9 months),
   - 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,
   - bitewing (once every 6 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 prophylaxis (once every 9 months),
   - topical application of fluoride,
   - oral hygiene instruction (once every 9 months,

- caries control,
- interproximal discing of teeth,
- recontouring of teeth for functional reasons,
- occlusal equilibration (8 units of time every 12 months)

e. space maintainers

f. restorations:

- amalgam
- retentive pins
- acrylic or composite resin
- stainless steel crowns

g. anaesthesia

h. in-office laboratory procedures

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses for replacement of space maintainers which have been lost, stolen or mislaid,
4. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
5. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Endodontic and Periodontic Benefit

Eligible Expenses

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

a. periodontics
   - non surgical services,
   - surgical services
   - post-surgical treatment,
   - scaling and root planning,
   - adjunctive procedures,
   - alveoplasty

b. endodontics
   - pulpotomy,
   - root canal therapy,
   - periapical services,
   - other endodontic procedures,
   - emergency procedures

c. in office laboratory procedures

Dental Insurance Provision – Denture Repair Benefit

Eligible Expenses

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

a. repairs and adjustments
   - adjustment to dentures,
   - repairs/additions to dentures,
   - denture rebasing and relining

b. in office laboratory procedures

Dental Insurance Provision – Surgical Removal Benefit

Eligible Expenses

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

a. surgical services
   - uncomplicated removals,
   - surgical removals

b. in office laboratory procedures

Dental Insurance Provision – Surgical Services and Drug Benefit

Eligible Expenses

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

a. surgical services
   - surgical exposure, transplantation and repositioning,
   - surgical excision,
   - surgical incision,
   - fractures,
   - frenectomy,
   - miscellaneous surgical services

b. adjunctive general services
   - drugs (injections)
   - in office laboratory procedures

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).