Sun Life Financial

your group benefits

University of British Columbia

Retirement and survivor benefits program

Contract Number 20605
Effective April 1, 2017

Table of Contents

General Information

About this booklet

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

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

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

Information at your fingertips

For information about your group benefits or claims, you can also 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 web site. 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*

Eligibility

To be eligible for group benefits you must be a resident of Canada.

You will become eligible for retiree coverage at the end of your UBC employment and the day after your coverage terminates under University of British Columbia plan 25205 or a comparable spousal benefits plan and you are over age 55, provided you apply for benefits within 31 days from the date of eligibility. You are also eligible if you are a surviving dependent of a UBC employee who has passed away at any age and were covered under their University of British Columbia plan 25205.

If you are still an active employee but have reached the maximum pensionable age as defined by the Income Tax Act (Canada), you will be eligible to immediately participate in this plan provided you apply for benefits within 31 days of reaching the maximum pensionable age. The maximum pensionable age at January 1, 2008 as defined by the Income Tax Act as the end of the calendar year in which they turn 71.

For Extended Health Care, you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 19.

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

A child for whom you or your spouse is the primary caregiver and who has been granted custody and control, is also considered an eligible dependent, provided the child is entirely dependent on you or your spouse for financial support and is

- Under age 19, or

- age 19 or over but under age 25 who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada).

A dependent child will have their coverage terminated at the end of the month they attain the limiting age.

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

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

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

Enrolment

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request dependent coverage. Applications for coverage must be made within 31 days from the date of eligibility.

As of March 1, 2009, you must elect to enrol for the coverage as per the plan or forfeit this coverage with no option to enroll at a future date regardless if you are a member of another plan with comparable coverage.

When coverage begins

Your coverage begins on the later of the following dates:

- the date you become eligible for coverage.
- the date your employer receives your enrolment information for coverage.
- the date Sun Life approves your proof of good health, if required.

A dependent's coverage begins on the later of the following dates:

- the date your coverage begins.
- the date the dependent becomes eligible for coverage.
- the date Sun Life approves the dependent's proof of good health, if required.

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

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

- change of dependents.
- change of name.

- change of beneficiary.

Accessing your records

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

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

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

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

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

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

When coverage ends

As a retiree, your coverage will end on the earlier of the following dates:

- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

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

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

- the date the person would no longer be considered your dependent if you were still alive.
- the end of the period for which premiums have been paid for dependent coverage.
- the date the benefit provision under which the dependent is covered terminates.

Replacement coverage

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

Services provided by a doctor

Many of the provisions under this plan require the involvement of a doctor. When a doctor's involvement is required, the doctor must be a person other than you, your spouse or immediate family member.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. The necessary claim forms are available from your Department of Human Resources which you may make photocopies of these forms. Alternatively, you can download them from the Human Resources website at www.hr.ubc.ca/benefits or access them through the Sun Life Plan Member site at www.mysunlife.ca (after you have ascertained your Access Id and PIN).

Please ensure original receipts are attached to your claim form and we recommend that you keep copies of both your original receipts and claim form. Photocopies of receipts are only acceptable when coordinating a claim and must be accompanied by the explanation of benefits from the other carrier.

Claims may be submitted electronically for some expenses.

If you require further information concerning your benefits, please call the Sun Life Customer Care Centre at 1 800 361-6212. You will need to provide your contract number (20605) and certificate number (member ID) for personal identification. If you enrolled onto the plan prior to January 1, 2003 your member ID is your Social Insurance Number (SIN), if you enrolled onto the plan on or after January 1, 2003 your member ID is your UBC employee ID.

For dental claims, we will access the Standard Generic claim form from your dentist or you may choose to submit your dental claim online through the Sun Life Plan Member site.

Legal actions

Limitation period for Ontario:

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

Limitation period for any other province:

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

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical examination

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

Recovering overpayments

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

Definitions

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

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

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

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

Retiree A retiree is a person who has retired from active service with the employer and is eligible for benefits as determined by the employer.

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

Extended Health Care
(Medicare Supplement)
Plans 1, 2 and 3

Elections

For all persons enroled under this plan prior to November 1, 2003: you are covered under Plan 1 or Plan 2, as elected at the time of enrolment, for you and your dependents.

For all persons enroled under this plan on or after November 1, 2003: you are covered under Plan 3 for you and your dependents.

Lifetime maximum benefit

Plan 1, under Extended Health Care, the maximum amount we will pay for any person is $15,000.

Plan 2, under Extended Health Care, the maximum amount we will pay for any person is $50,000.

Plan 3, under Extended Health Care, the maximum amount we will pay for any person is $200,000.

It is important that you report any of the following changes to your employer:

- If you have single coverage and you have reached the lifetime maximum benefit – contact your employer to terminate coverage.
- If you have couple/family coverage and you have reached the lifetime maximum benefit – contact your employer and advise whether you would like to continue coverage for your dependents.
- If you have couple/family coverage and your dependents have reached their lifetime maximum benefit – contact your employer to terminate coverage for your dependents.

General description of the coverage

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

Extended Health Care coverage pays the reasonable and customary charges for eligible services or supplies for you that are medically necessary for the treatment of an illness and have been recommended or prescribed by a doctor.

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

This plan and its administrative practices were developed based on the Canada Health Act which requires all provinces and territories to cover the cost of all medically necessary hospital services, including medically necessary in-patient and out-patient services such as drugs administered in a hospital. This means that if you are administered a drug in a hospital, either through in-patient or on an out-patient basis, the cost of the drug will not be eligible for reimbursement under this plan. There is also no provision in our plan to support the reimbursement of administration fees (i.e. a fee charged to a patient to administer a drug in a hospital either through in-patient or on an out-patient basis). You are encouraged to seek coverage for such hospital prescription drugs from the provincial government or health authority.

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

The benefit year is from January 1 to December 31.

Deductible

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

Plan 1 The deductible is $50 each benefit year for each person up to a maximum of $50 per family.

Plan 2 The deductible is $100 each benefit year for each person up to a maximum of $100 per family.

Plan 3

The deductible is $1,000 each benefit year for each person up to a maximum of $1,000 per family.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

If 2 or more members of your family suffer injuries in the same accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.

Reimbursement level

For all eligible expenses, the reimbursement levels are described below:

However, for prescription drugs, in-province hospital, medical services and equipment and paramedical services combined, the reimbursement levels described below apply to the first $1,000 of paid claims per person per benefit year. Thereafter, any eligible expenses per person per benefit year are paid at 100%.

Prescription drugs

After you pay the deductible, we will cover 80% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins (allergy extracts with a DIN and allergy serums when administered by a doctor).
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- B12 injections for the treatment of pernicious anemia.
- colostomy supplies.

- treatments for weight loss if medically necessary and ordered in writing by a doctor with an indication of duration of treatment and body mass index.

Payments for any single purchase are limited to quantities that can reasonably be used in a 90 day period.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- proteins and food or dietary supplements.
- hair growth stimulants.
- contraceptives.
- products to help you quit smoking.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- oral contraceptives, any drug, vaccine, item or service classified as preventative treatment or administered for preventative purposes, HCG injections and general anaesthetic.

Prior authorization program

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

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

You will be covered for these drugs if the information you and your doctor provide meets our medical criteria. If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

Other health professionals allowed to prescribe drugs

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

Hospital expenses in your province

We will cover 80% of the costs for hospital care in the province where you live, after you pay the deductible.

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

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

Expenses out of your province

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

We will cover the cost of:

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

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

Emergency services

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

We will only cover services obtained within 90 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered for 90 days except where transportation would endanger the life of the patient, in which the 90 day limit will be extended.

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*).

In the **USA** and **Canada**, call: 1 800 511-4610
From anywhere else: 1 519 514-0351
Call collect through an international operator.

Fax: 1 519 514-0374

All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

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

Emergency services excluded from coverage

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Allianz Global Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had

unreasonably refused or neglected to receive the recommended medical services.

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

Medical services and equipment

We will cover 80% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a dentist does not require a doctor's order). All services require a pre-authorization for expenses in excess of $5,000.

- in-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of 720 hours per person per benefit year.

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

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

- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received

within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the retiree lives. The guide must be the current guide at the time that treatment is received.

- wigs as a result of medical treatment or injury, up to a lifetime maximum of $500 per person. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- grab bars for toilets, showers and beds that are medically necessary and purchased from a medical supplier. For expenses incurred for a grab bar, coverage is limited to the reasonable and customary charges.
- casts, splints, trusses, braces, cane, cane tips, walkers or crutches excluding elastic or foam supports.
- TENS (transcutaneous electric nerve stimulators) and TEMS (transcutaneous electric muscle stimulators).
- breast prostheses required as a result of surgery.
- surgical brassieres required as a result of surgery, up to a maximum of $150 per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of $200 per person in a benefit year.
- elastic support stockings, including pressure gradient hose, with 20 – 29 mm Hg compression, up to a maximum of 2 pairs per

person in a benefit year.

- pressure gradient hose, with 30 – 40 mm Hg compression, no maximum.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $200 in a benefit year for a person under age 19 or $400 in a benefit year for any other person.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $400 per dependent child over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy with a pre-authorization.
- oxygen, plasma and blood transfusions.
- aerochamber with a pre-authorization.
- catheter with a pre-authorization.
- (CPAP) constant positive airway pressure with a pre-authorization.
- cystic fibrosis equipment with a pre-authorization.
- dialysis machine with a pre-authorization.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- inhalation appliance/device for drug administration and Maxi Mist nebulizer when required for chronic lung disorder.
- cardiac screener.
- insulin pump and maintenance with a pre-authorization, if basic methods of insulin delivery are not feasible.

Paramedical services

We will cover 80% of the costs after you pay the deductible, up to the maximums listed below:

- registered/licensed clinical psychologists, when ordered by a doctor, up to a maximum of $100 per person in a benefit year. This maximum includes psychological testing.
- licensed speech therapists, acupuncturists, podiatrists or chiropodists, up to a maximum of $100 per person in a benefit year for each category of paramedical specialists.
- licensed physiotherapists or massage therapists, up to a combined maximum of $250 per person in a benefit year.
- licensed naturopaths or chiropractors, up to a combined maximum of $200 per person in a benefit year.

Licensed psychologists and massage therapists require a doctor's referral every 12 months. We will also accept referrals for pregnant women from midwives, who are registered with a provincial body governing midwives in Canada.

All of the above practitioners must be licensed to practice where that practice is located and services must be received in Canada or the United States. All receipts submitted for reimbursement must include all the following information:

- date(s) of service.
- name of patient.
- name of practitioner.
- credentials and/or qualifications of provider as well as professional affiliations with any regulatory body or society, i.e. Canadian Naturopathic Association.
- license number (RIPP = Registered in Province of Practice).
- amount (total cost per visit or per hour).
- breakdown of charges.
- rate per hour if the visit is longer than one hour.

Handwritten receipts will be accepted as long as all of the above details are provided on the receipt.

Payments after coverage ends

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies 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.
- services of an optometrist or ophthalmologist or cost of contact lenses, eyeglasses or laser eye correction surgery.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- services that Sun Life considers ineligible (examples of these services are such as but not limited to services of Victorian Order of Nurses or graduate or license practical nurses, services of religious or spiritual healers, services of occupational therapists, services of social workers, services of visual therapists, services of ergonomists, services and supplies for cosmetic purposes, public ward accommodation or rest cures).
- charges for completions of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payments charges, non-sharable or capital costs levied by local hospitals.
- charges for pre-existing conditions requiring continuous or

routine medical care while outside your province of residence.

- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, personal comfort items, items purchased for athletic use, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- 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.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- hospital out-patient fees and user fees.
- enuresis equipment and Mozes Detector.
- services of osteopaths.
- osteopath, chiropractor, podiatrist or chiropodist x-ray examinations.
- ultrasound.
- traction kit.
- ear plugs.
- blood sampling.
- services of a kinotherapist, reflexologist, sexologist, sex therapist

and shiatsu specialist.

- services or supplies for which no charge would have been made in the absence of this coverage.

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

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated.
- participation in a criminal offence.

Integration with government programs

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

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

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

When and how to make a claim

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

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

- December 31 of the benefit year following the year during which you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage.

Emergency Travel Assistance

General description of the coverage

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

If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (*Allianz Global Assistance*) can help.

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers services that you obtain within 90 days of leaving the province where you live. If hospitalization occurs within this period, in-patient services are covered for 90 days except where transportation would endanger the life of the patient, in which the 90 day limit will be extended.

A Travel card may be printed off the Sun Life website *www.mysunlife.ca* or from your Department of Human Resources.

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

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

Getting help

At the time of an emergency, you or someone with you must contact Allianz Global Assistance:

In the **USA** and **Canada**, call: 1 800 511-4610
From anywhere else: 1 519 514-0351
Call collect through an international operator.

Fax: 1 519 514-0374

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

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

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

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

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

Allianz Global Assistance will transmit an urgent message from you to

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

medical emergency.

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

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

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

Limits on Emergency Travel Assistance coverage

There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure. . Please consult the telephone numbers on the Travel card.

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

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- the refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Allianz Global Assistance

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

Dental Care

General description of the coverage

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

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

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

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics or paedodontics whose dental practice is limited to that speciality, then the fee guide used will be the lesser of the Specialist fee guide or the Dental Association Fee Guide for general practitioners in the province where the treatment is received plus 10%.

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

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

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

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than $1,500 per person for each benefit year for all services.

Predetermination

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

Preventive dental procedures

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

We will pay 70% of the eligible expenses for these procedures.

Oral examinations

You are covered for the following complete, recall or specific oral examinations.

- 2 complete examination per lifetime.
- recall and new patient examinations, combined maximum of 2 per person per benefit year.
- specific examinations, combined maximum of 2 per person per benefit year.

- emergency examination.

X-rays

1 panorex every 5 years.

1 complete series of x-rays every 3 years.

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

Other services

Required consultations with another dentist.

Consultation with the patient.

Pulp vitality tests, limited to one unit of time per quadrant every 6 months.

Diagnostic models, unmounted, trimmed, limited to one set in a benefit year.

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

Emergency or palliative services.

Removal of impacted teeth and related anaesthesia.

Provision of fixed space maintainers.

Pit and fissure sealants and preventative restorative resins, once per tooth every 2 years

Basic dental procedures

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

We will pay 70% of the eligible expenses for these procedures.

Fillings

You are covered for amalgam fillings (silver) and composite or acrylic fillings (white fillings) or equivalent. You are only covered for composite fillings on anterior and bicuspid teeth.

On permanent posterior (molar) teeth and all primary teeth, only the

bonded amalgam rate is covered for composite fillings.

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

Pre-fabricated metal or plastic restorations This coverage is only available when a permanent crown is not being installed. You are covered for pre-fabricated metal or plastic restorations, including stainless steel crown once per tooth every 2 years.

This procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, and cementation of crown.

Endodontics Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue, once per tooth. Bone and tissue grafts are not covered.

Periodontics Treatment of disease of the gum and other supporting tissue:

- scaling and root planing (tartar removal), limited to 15 units of 15 minutes (1 unit = 15 minutes) per person in a benefit year.
- gingival curettage, limited to 1 gingival curettage per site per benefit year.
- 2 bruxism appliances every 5 years.
- oral manifestations, oral mucosal disorders.
- occlusal equilibration and adjustments.

Oral surgery Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*). You are covered for anaesthesia only when you have eligible complicated oral surgery.

Rebase or reline Rebase or reline of an existing partial or complete denture. You are covered for 2 of these in any 24 month period.

Tissue conditioning You are covered for 4 of this procedure every 5 years.

Repair Repair of bridges or dentures.

Major dental procedures

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

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

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

All major dental procedures are limited to once every 5 years from the date of insertion when the same tooth is involved.

Crowns This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. It does not include porcelain or porcelain fused to metal for molar teeth. Crowns are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

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

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

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery

charges, are not covered.

Payments after coverage ends

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

What is not covered

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- services or supplies 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.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of

prosthetic splinting (capping teeth and joining teeth together to provide additional support).

- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.
- participation in a criminal offence.

When and how to make a claim

To submit a claim, complete the claim form (for further information on making claims, please refer to the general information section on making claims). Claims may be submitted electronically for some expenses.

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

- 1 year after the date in which you incur the expenses, or
- 90 days after the end of your Dental Care coverage.

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

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. 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).