



**Secondary Teachers and PSSP**

**Contract Number 56246 and 25246  
Effective January 1, 2007**



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## General Information

### About this booklet

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

The contract holder, Upper Canada District School Board, has the sole legal and financial liability for the following benefits:

- Extended Health Care
- Dental Care

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

### Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a full-time or part-time employee.
- you are actively working for your employer at least 0.5 of the normal workweek as determined by your employer or in accordance with the terms of your collective agreements.

There is no waiting period for your group plan.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

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 or the United States.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (including foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

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

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

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

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

**Enrolment**

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.

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

**When coverage begins**

Your coverage begins on the date you become eligible for coverage.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

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.

Once you have dependent coverage, any subsequent dependents will be covered automatically.

If you are not actively working on the date your spouse's Optional Life

coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

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 employment status may change, or 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 exceptions apply if the result of the change is an increase in coverage:

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- 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.

**When coverage ends**

As an employee, your coverage will end on the earlier of the following dates:

- the date your employment ends.
- the date you are no longer actively working.
- for insured benefits: 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.
- for insured benefits: 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 employee benefits booklet.

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

- 3 months after the date of your death, for Dental Care.
- 24 months after the date of your death, for Extended Health Care.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

The continuation of coverage does not apply to the spouse's Optional Life.

**Replacement coverage**

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

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

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

**Making claims**

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

No legal action may be brought by you more than one year after the date we must receive your claim forms or more than one year after we stop paying disability benefits.

**Proof of disability**

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

**Coordination of benefits**

If you 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 where you should send a claim first. Here are some guidelines:

- if you are claiming expenses for your spouse and the spouse is covered for those expenses under another plan, you must send the claim to your spouse's plan first.
- if you are claiming expenses for your children, and both you and

your spouse have coverage under different plans, you must claim under the plan of the parent with the earlier birthday (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 maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

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 employee 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.

***Basic earnings*** Basic earnings are the salary you receive from your employer excluding any bonus, overtime or incentive pay.

***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.

***Retirement date*** If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

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

## Extended Health Care (Medicare Supplement)

<b>General description of the coverage</b>	<p>The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.</p> <p>In this section, <i>you</i> means the employee and all dependents covered for Extended Health Care benefits.</p> <p>Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.</p> <p>The benefit year is from September 1 to August 31.</p>
<b>Deductible</b>	<p>The deductible is the portion of claims that you are responsible for paying.</p> <p>For prescription drugs the deductible is the portion of any dispensing fee over \$6.47 for each prescription or refill.</p> <p>For other expenses, there is no deductible.</p>
<b>Reimbursement level</b>	<p>For all eligible expenses combined, excluding the prescription drug dispensing fee and referred services, the reimbursement levels described below apply to the first \$1,000 of expenses per person or family per benefit year. Thereafter, any eligible expenses in excess of \$1,000 per person or family per benefit year, other than referred services, are paid at 100%.</p>

**Prescription drugs**

We will cover 90% of the cost of drugs and supplies that are prescribed in writing by a doctor or dentist and are obtained from a pharmacist.

For the following expenses you should use your drug card:

- medication listed in the Federal or Provincial Drug Schedules which has a Drug Identification Number (DIN) and requires a prescription.
- injectable drugs and vitamins, insulin and allergy extracts with a DIN.
- preparations and compounds of which at least one ingredient is an eligible drug under this benefit.
- diabetic supplies.
- drugs for the treatment of infertility up to a lifetime maximum of \$2,400 for each person.
- drugs for the treatment of erectile dysfunction, up to a maximum of \$1,200 per person in a benefit year.

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

- vaccines and compound serums that require a prescription, including but not limited to Hepatitis.
- intrauterine devices (IUDs).
- colostomy supplies.

We will cover the cost of the above medicines and supplies after you pay the deductible.

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

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

If you are taking medications not listed above on a maintenance basis, you may apply for a 100 day supply to be allowed by submitting a *Request for 100-day Supply for Acute Drugs* form, available from your benefits administrator.

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

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

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

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

**Hospital expenses in your province**

We will cover 100% of the costs for hospital care in the province where you live.

We will cover:

- out-patient services in a hospital and the difference between the cost of a ward and a semi-private hospital room.
- the cost of room and board in a chronic care hospital including a chronic care facility and chronic care in a nursing home, if this care has been ordered by a doctor, up to \$10 per day to a maximum of 120 days for all periods of treatment of an illness due to the same or related causes.
- private hospital charges up to \$10 per day to a lifetime maximum of 120 days.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

The maximum amount payable is \$20 per day up to a maximum of 180 days for treatment of an illness due to the same or related causes.

For purposes of this plan, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged, sanatorium or a facility for treating alcohol or drug abuse.

For purposes of this plan, a *chronic care hospital* is a facility licensed to provide care for chronically ill patients on in-patient basis, who have a life expectancy of 6 months or less. Nursing care must be available 24 hours a day. It does not include a rest home, home for the aged, sanatorium, or a facility for treating alcohol or drug abuse.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest

home, home for the aged, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

A *private hospital* is a hospital not covered by Medicare.

**Expenses out of your province**

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

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

- for emergency services:
  - the difference between the cost of a ward and a semi-private hospital room for services provided outside the province where you live but within Canada.
  - a ward for services provided outside of Canada, up to a maximum of 31 days for all periods of treatment of an illness due to the same or related causes.
- for referred services, a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

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

***Emergency services*** We will pay 90% of the cost of covered emergency services.

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

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, Worldwide Assistance Services, Inc. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Worldwide 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 Worldwide Assistance cannot be made before services are provided, contact with Worldwide 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.

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

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

Sun Life or Worldwide 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.

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 Worldwide Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Worldwide 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.

*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 Worldwide Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.

- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

**Referred services** *Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 80% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

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

**Medical services and equipment** We will cover 90% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of \$25,000 per person during any 3 consecutive benefit years.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- the following diagnostic services rendered out of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
- 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 employee lives. The guide must be the current guide at the time that treatment is received.
- services of an ophthalmologist or licensed optometrist, up to a maximum of \$50 per person over 2 benefit years, once we receive proof that the provincial medicare plan has paid its maximum benefit.
- wigs following chemotherapy, up to a maximum of \$300 per person in a benefit year. 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.

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- devices required for sleep apnea after the Assistive Devices Programme has paid.
  - casts, splints, trusses, braces or crutches.
  - breast prostheses required as a result of surgery, up to a maximum of \$400 per person every 2 benefit years.
  - surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
  - artificial limbs and eyes, including repairs.
  - stump socks, up to a maximum of 5 pairs per person in a benefit year.
  - elastic support stockings, including pressure gradient hose, up to a maximum of 2 pairs per person in a benefit year.
  - custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of \$350 per person in a benefit year.
  - custom-made orthopaedic shoes or modifications to orthopaedic shoes, if an integral part of a brace, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of \$500 per person in a benefit year.
  - radiotherapy or coagulotherapy.
  - oxygen, plasma and blood transfusions.
  - glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of \$700 per person.

**Paramedical services**

We will cover 90% of the costs, up to a maximum of \$400 per person in a benefit year for each category of paramedical specialists listed below (practitioners must be licensed by the appropriate governing board in the province where treatment is given):

- licensed massage therapists, when ordered by a doctor.

- licensed speech therapists, psychologists, acupuncturists or naturopaths (naturopaths must be registered with the Association of Drugless Therapy).
- licensed osteopaths, chiropractors, podiatrists or chiroprodists including a maximum of one x-ray examination per specialty each benefit year.

For licensed physiotherapists, we will cover 90% of the costs, up to a maximum of \$750 per person per benefit year.

**Contact lenses, eyeglasses or laser eye correction surgery**

We will cover the cost of contact lenses, eyeglasses, prescription sunglasses or laser eye correction surgery. Contact lenses, eyeglasses or sunglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

We will cover 100% of these costs up to a maximum of \$275 per person in any 24 month period.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.

**When coverage ends**

Extended Health Care coverage will end on August 31 coincident with or immediately following the day the employee reaches age 70 or the last day of the month in which the employee retires whichever comes first.

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

**Payments after coverage ends**

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

- during the uninterrupted period of total disability,

- within 90 days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, 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 unless explicitly listed as covered under this benefit.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- 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).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

**When and how to make a claim**

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

In order for you to receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your Extended Health Care coverage.

## Dental Care

**General description  
of the coverage**

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

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

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

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. Effective each September 1 to December 31, the payments will be based on the current fee guide at the time the treatment is received. From January 1 to August 31, the payments will be based on the previous year's fee guide at the time the treatment is received.

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.

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.

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

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

The benefit year is from September 1 to August 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 Major dental procedures.

Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.

**Lifetime maximum**

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

**Predetermination**

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$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 100% of the eligible expenses for these procedures.

*Oral examinations* 1 complete examination every 24 months.

1 recall examination:

- every 9 months, for persons age 18 and over.
- every 6 months, for persons under age 18.

Emergency or specific examinations.

*X-rays* 1 complete series of x-rays or 1 panorex every 24 months.

1 set of bitewing x-rays:

- every 9 months, for persons age 18 and over.
- every 6 months, for persons under age 18.

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

*Other services* Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once:

- every 9 months, for persons age 18 and over.
- every 6 months, for persons under age 18.

Habit breaking appliances for children under age 19.

Emergency or palliative services including the cost of medication and its administration, by injection, in a dentist's office.

Diagnostic tests and laboratory examinations.

Treatment for the relief of pain.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants on molars, for children under age 15.

Oral hygiene instruction once every 5 months, up to a maximum of 2 sessions per benefit year.

**Basic dental procedures**

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

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

*Fillings* Amalgam, composite, acrylic or equivalent.

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

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

*Endodontics* Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

*Periodontics* Treatment of disease of the gum and other supporting tissue, excluding temporomandibular joint (TMJ) treatment. Scaling is limited to 8 units of time.

*Oral surgery* Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).

**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.

*Implants* Implant related crowns, bridges or dentures, limited to the charges for the least expensive alternate procedure that would have been covered under this plan. All other charges related to implants, including surgery charges, are not covered.

*Major restorations* Inlays and onlays. Crowns and repairs to crowns, other than

prefabricated metal restorations (*Basic dental procedures*).

**Repair** Repair of bridges or dentures.

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

**Prosthodontics** Construction and insertion of bridges or standard dentures, after the person has been covered continuously under this provision for a period of 12 months. 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.

**Orthodontic procedures**

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

Only children under age 19 are covered for these procedures.

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

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

The following orthodontic procedures are covered:

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

**When coverage ends** Dental Care coverage will end on August 31 coincident with or

immediately following the day the employee reaches age 70 or the last day of the month in which the employee retires whichever comes first.

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

**Payments after coverage ends**

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

**What is not covered**

We will not pay for services or supplies payable 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.
- 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).

- charges related to the temporomandibular joint (TMJ) treatment.
- 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 make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form.

In order for you to receive benefits, we must receive a claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your Dental Care coverage.

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

## Life Coverage

**General description of the coverage** Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.

**Basic Life coverage for you**

*Amount* Your Life benefit is 1 times your annual basic earnings, rounded to the next higher \$1,000. The maximum amount of coverage is \$200,000.

*Coverage ends* Your coverage will end on August 31 coincident with or immediately following the day the employee reaches age 70 or the last day of the month in which the employee retires whichever comes first. Coverage may also end on an earlier date, as specified in *General Information*.

**Optional Life coverage for you**

*Amount* You can choose coverage in units of \$20,000. The maximum amount of coverage is \$300,000.

*Coverage ends* Your coverage will end on August 31 coincident with or immediately following the day the employee reaches age 70 or the last day of the month in which the employee retires whichever comes first. Coverage may also end on an earlier date, as specified in *General Information*.

**Optional Life coverage for your spouse**

*Amount* You can choose Optional Life coverage for your spouse in units of \$20,000 up to a maximum of \$300,000.

*Coverage ends* Optional coverage for your spouse will end on August 31 coincident with or immediately following the day the employee reaches age 70 or the last day of the month in which the employee retires whichever comes first. Coverage may also end on an earlier date, as specified in

*General Information.***Who we will pay**

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

**Coverage during total disability**

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for at least an uninterrupted period of 6 months.

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

Spouse Optional Life coverage will also continue without payment of

premiums, as long as your Life coverage is continued without payment of premiums, but not after the Spouse Optional Life benefit is terminated.

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience.

**Converting Life coverage**

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

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

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

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

**When and how to make a claim**

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



