

your **group**
benefits

McMaster University

**Retired Clinical Faculty between
July 1, 1998 and June 30, 2014 (Plan 4)**

**Contract Number 25018 and 50813
Effective September 1, 2021**

Issued December 30, 2021

McMaster University is pleased to provide eligible retired Clinical Faculty members with a comprehensive outline of the University sponsored benefit programs. These plans apply to eligible individuals who retired between July 1, 1998 and June 30, 2014.

McMaster University provides eligible retired members with the Extended Health Care, Dental, and Group Life as part of the many valuable benefits available to you upon retirement. This booklet is supplied by Sun Life and contains detailed coverage information of the benefits provided through Sun Life.

The Extended Health Care benefit is provided in combination with the provincial health plan, in order to protect both you and your eligible dependants against the cost of a wide range of medically necessary services and supplies. To be eligible for coverage under the Extended Health Care plan with Sun Life you must be covered under your provincial health plan. For further information on your provincial health care coverage, please contact your local provincial health care office. Coverage for emergency expenses outside your province is minimal; we recommend that you purchase additional coverage appropriate for the location where you will be traveling.

Should you have any questions regarding your benefit coverage, please contact Sun Life directly at 1.800.361.6212 or your employer. Alternatively, you may contact your Human Resources representative or visit <https://hr.mcmaster.ca> for information regarding your benefits and claims procedures.

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Benefit Summary

This is a general summary of the coverage provided under your group plan and should be read together with the information contained in this booklet. For more information, including exclusions, limitations and other conditions, please refer to the appropriate sections of this booklet.

General Information

Waiting Period	None
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Summary. Coverage may also end on an earlier date, as specified in the <i>General Information</i> section of this booklet.

Extended Health Care – 25018

Benefit year	July 1 to June 30
Deductible	For general medical devices – \$50 per person, per benefit year For prescription drugs – the portion of any dispensing fee over \$6.50 for each prescription or refill For other expenses: None
Reimbursement level	
<i>Prescription drugs</i>	100% after the deductible
<i>In-province hospital</i>	100%, without the deductible, of the difference between the cost of a ward and a semi-private hospital room up to a maximum of \$110 per day.
<i>Convalescent hospital</i>	100%, without the deductible, up to \$20 per day for a maximum of 120 days in a benefit year
<i>Out-of-province emergency services</i>	100% without the deductible Maximum of 60 days per trip Lifetime maximum of \$10,000 per person for out-of-province services
<i>Out-of-province referred services</i>	80% without the deductible

<i>Private duty nurse services</i>	40% of the first \$25,000 of eligible expenses (equals \$10,000) and where eligible expenses exceed \$25,000, we will pay 80% of the next \$25,000 (equals \$20,000) of eligible expenses per person without the deductible
<i>Ambulance services</i>	100% without the deductible
<i>Tests and services</i>	100% without the deductible
<i>Hearing aids</i>	75% of the costs of hearing aids, without the deductible, up to a maximum of \$500 per person per ear over a period of 3 benefit years. 100% of the costs of the initial purchase of a hearing aid, without the deductible, if required as the result of an accident
<i>Orthotics and orthopaedic shoes</i>	80% of the costs of custom-made orthotic inserts for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes, without the deductible, up to a maximum of \$400 per person over a period of 2 benefit years
<i>General medical devices</i>	75%, after the deductible, for the first \$400 of eligible expenses and 100% of the remainder of expenses per person in a benefit year
<i>Other medical services and equipment</i>	100% without the deductible
<i>Paramedical services</i>	We will cover 100% of the costs, without the deductible, up to the maximum for the paramedical specialists listed below: <ul style="list-style-type: none"> ■ licensed speech therapists, up to a maximum of \$200 per person per benefit year ■ licensed psychologists – \$15 per half hour for the initial visit and \$15 per visit for subsequent visits, up to a maximum of \$225 per person per benefit year ■ licensed physiotherapists – \$15 per visit, up to a maximum of \$225 per person per benefit year ■ licensed massage therapists, when ordered by a doctor – \$15 per visit, up to a maximum of \$225 per person per benefit year ■ licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, podiatrists or chiropodists – \$15 per visit, up to a maximum of \$225 per person per benefit year per practitioner. Also included is one x-ray examination per specialty each benefit year ■ licensed naturopaths – \$15 per visit, up to a maximum of \$225 per person per benefit year ■ licensed Christian Science Practitioner – \$15 per visit, up to a maximum

of \$225 per person per benefit year

Vision care –Contact lenses, eyeglasses or laser eye correction surgery (for the retiree only) We will cover 100% of these costs, without the deductible, up to a maximum of \$150 per retiree where the period between purchases is 24 months and \$200 where the period exceeds 3 years

100% of the cost for the initial purchase of prescription glasses, without the deductible, if required as the result of an accident

Dental Care – 25018

Benefit year July 1 to June 30

Deductible None

Fee guide The current fee guide for general practitioners in the province of Ontario

Reimbursement level

Preventive procedures 100%

Basic procedures 85%

Major procedures 70%

Orthodontic procedures 50%

Maximum benefit

Benefit year maximum Major procedures – \$2,000 per person

Lifetime maximum Orthodontic procedures – \$2,000 per person

Life – 50813***Employee Basic Life***

Amount \$5,000

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 McMaster's group plan 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 McMaster University.

The contract holder, McMaster University, self-insures the following benefits:

- Extended Health Care
- Dental Care

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

Eligibility

Eligible retired members, must also be a resident of Canada and must have been enrolled in the group benefit plan immediately prior to your retirement.

To be eligible for coverage under the Extended Health plan with Sun Life you must be covered under your provincial health plan. For further

information on your provincial health care coverage, please contact your local provincial health care office.

Who qualifies as your dependent

Your dependent must:

- be your spouse or child, and
- be a resident of Canada or the United States, and
- maintain provincial health coverage, and
- be listed as a dependent at the time of retirement.

To be eligible, your spouse must be legally married to you, or be 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, provided that you are not legally married. You can only cover one spouse at a time. Coverage is extended only to the person legally represented as your spouse at the time of retirement.

Your children and your spouse's children (other than foster children) are eligible dependents:

- who are unmarried and under age 21.
- for whom you have actual custody or legal financial responsibility.

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 and you have actual custody or legal financial responsibility.

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. McMaster can give you more information about this.

Enrolment You have to enrol to receive coverage. To enrol, contact McMaster University to complete the necessary enrolment forms. You must also enrol your eligible dependents in order for them to receive coverage.

When coverage begins Your coverage begins on the date you retire. If you have single coverage at the time of retirement, you cannot convert to family (dependent) coverage at a later date.

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

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 Human Resources Representative at McMaster University:

- in the event your spouse dies or you are no longer married.
- change of name.
- change of beneficiary.
- coverage students.
- change of address.

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 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 benefit provision under which you are covered terminates.

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 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 until the earlier of the following dates:

- 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.

Replacement coverage

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

Sun Life will not be responsible for paying benefits if an insurer under

a previous group contract is responsible for paying similar benefits.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your Human Resources Representative at McMaster University to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

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

Claims services

The following services have been set up to assist you in better understanding your Benefit Programs. You may direct your questions,

comments or concerns to your Human Resources Representative at McMaster University.

If you have a question concerning a specific medical or dental claim, please call Sun Life at 1-800-361-6212. Your name, policy (25018) and certificate number (retiree I.D. number), which are shown on your Sun Life card should be provided. You may also e-mail Sun Life at askus@sunlife.com.

In addition to the above information, please include your spouse or dependents' name as applicable, type of claim and your phone number.

If the question is about a claim that has already been paid or declined, provide the "claim" or "control" number located on your Explanation of Benefits (EOB).

If you have a question concerning your coverage for Life Insurance, please contact your Human Resources Representative at McMaster University.

If you need forms for claims or to make positive enrolment changes please contact your Human Resources Representative at McMaster University or access the forms on line at <https://hr.mcmaster.ca> on their website.

All eligibility issues are between you and the University. Sun Life pays claims based on information you provide to the University. If claims are submitted and you have not enrolled your dependents, they will not be covered. Only expenses incurred after the date of enrolment can be honoured. If a problem arises, call your Human Resources Representative at McMaster University.

All questions regarding what constitutes reasonable and necessary expenses are determined by the insurer in accordance with our contract and common practices within the insurance industry for policies of this type. Where you have questions that concern a particular treatment, or plan of treatment, you should contact Sun Life.

**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.

McMaster University can help you determine which plan you should claim from first.

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

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

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

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

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

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

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

Extended Health Care (Medicare Supplement)

Plan administrator	<i>This benefit is administered by Sun Life Assurance Company of Canada on behalf of McMaster University.</i>
General description of the coverage	<p>The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.</p> <p>In this section, <i>you</i> means the retiree and all dependents covered for Extended Health Care benefits.</p> <p>Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. <i>Medically necessary</i> means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.</p> <p>To qualify for this coverage you must be a resident of Canada entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p><i>Reference to Doctor may also include a nurse practitioner</i> – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a doctor. For drugs, refer to <i>Other health professionals allowed to prescribe drugs</i>.</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 July 1 to June 30.</p>

Deductible

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

For general medical devices the deductible is \$50 each benefit year for each person.

For prescription drugs, the deductible is the portion of any dispensing fee over \$6.50 for each prescription or refill.

For other expenses, there is no deductible.

Prescription drugs

We will cover 100% 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.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility, up to a lifetime maximum of \$2,400 for each person.
- drugs for the treatment of sexual dysfunction, up to a maximum of \$1,200 per person in a benefit year.
- Xenical for the treatment of weight loss.
- vaccines that legally require a prescription.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

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

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements, except as noted above.
- hair growth stimulants.
- products to help you quit smoking.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

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 Plan maximum for hospital care in the province where you live.

We will cover out-patient services in a hospital, except for any services

explicitly excluded under this benefit, and the difference between the cost of a ward and a semi-private hospital room up to a maximum of \$110 per day.

Where the cost of the room exceeds this \$110 per day limit, and where the out-of-pocket cost for the hospital room exceeds \$300 per person per benefit year, your out-of-pocket eligible expenses beyond \$300 will be reimbursed.

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.

We will also cover the cost of confinement in a rehabilitation centre which is operated by the province of Ontario for treatment of drug addiction or alcoholism, provided the cost has been approved in writing by Sun Life.

The maximum amount payable for convalescent hospital or for a rehabilitation centre is \$20 per day up to a maximum of 120 days in a benefit year.

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

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

**Retirees living
outside of Ontario
but within Canada**

Medical benefits are continued regardless of where you choose to reside within Canada.

It should be noted, however, that Sun Life will not reimburse expenses which they would not have paid had you continued to reside in Ontario.

For instance, any prescribed drugs that would have been paid by the Ontario provincial health insurance plan for an individual over age 65 would not be reimbursed under our plan.

With regard to the "out of province" coverage, you are provided with coverage of \$10,000 (lifetime maximum) for emergency services outside your place of residence.

For instance if you live in Alberta, that would be your place of residence.

You must pay for services first, and then submit claims to Sun Life who will deduct the amount that the Ontario health insurance plan would have paid had you been a resident of Ontario and then pay up to the reasonable and customary rates for the region where the services were provided.

It should be noted that you should submit all bills since those items covered do change and no comprehensive list exists at any one time which could assist you.

Claims not submitted in English may cause problems which will lead to difficulty in payment of the claims. It is recommended that you take extra care in having your doctors and dentists clearly describe the treatments to enable the insurance company to properly adjudicate your claims.

**Expenses out of
your province**

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

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

- a semi-private hospital room up to a maximum of \$110 per day.
- hospital services, other than room and board, provided outside of Canada.

- out-patient services in a hospital.
- the services of a doctor.

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

Emergency services We will pay 100% of the cost of covered emergency services.

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

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

payments for all expenses related to that emergency.

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

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 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.

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.

***Emergency services
excluded from
coverage***

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

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

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 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.

***Emergency services
out of your province***

Expenses incurred for emergency services outside the province where you live are subject to a lifetime maximum of \$10,000 per person or, if lower, any other applicable lifetime maximum.

**Private duty nurse
services**

We will cover out-of-hospital private duty nurse services when medically necessary and when ordered by a doctor. 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.

We will cover 40% of the first \$25,000 of eligible expenses (equals \$10,000) and where eligible expenses exceed \$25,000, we will pay 80% of the next \$25,000 (equals \$20,000) of eligible expenses per person. Each benefit year after a claim has been paid, 1/2 of the amount utilized will be reinstated. After 2 benefit years with no claims, entitlement is returned to full coverage.

Ambulance services

We will cover 100% of the costs for the ambulance services listed below when ordered by a doctor.

- 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*.

Tests and services

We will cover 100% of the costs for the medical services listed below when ordered by a doctor.

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
 - laboratory tests.
 - ultrasounds.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- intravenous pumps.

Assistive medical devices guidelines/overview

All benefits payable under the provincial assistance devices program, or by any other group program or community organization should be claimed first.

Further information on the Ontario Assistive Devices Program (ADP) is available through the Operational Support Branch of the Ontario Ministry of Health and Long Term care.

Equipment must be ordered by a doctor as necessary for a medical condition.

The plan is intended to reimburse individuals for devices purchased that are considered reasonable and customary services or for expenses in the treatment of the illness or injury.

Devices necessary for sports and recreation are not covered.

The plan is limited to the purchase of one device for the intended purpose in any year and is not generally liable for lost or damaged devices, nor repair or maintenance or such devices, unless otherwise noted.

Devices may be replaced when the normal lifetime of such devices has expired.

All amounts eligible under the plan are based on expenses beyond those payments from other sources unless otherwise noted.

Hearing aids We will cover 75% of the costs of hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$500 per person per ear over a period of 3 benefit years. Repairs are included in this maximum.

We will also cover 100% of the costs of the initial purchase of a hearing aid prescribed by an ear, nose and throat specialist, if required as the result of an accident.

Orthotics and orthopaedic shoes We will cover 80% of the costs of custom-made orthotic inserts for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of \$400 per person over a period of 2 benefit years.

General medical devices

After you pay the deductible of \$50 per person each benefit year, we will cover 75% of the next \$400 of eligible expenses and 100% of the remainder of expenses per person in a benefit year for each category of medical services listed below when ordered by a doctor (For any rental, the deductible applies only in the first year.):

- home care devices required to care for the infirmed outside hospital, excluding costs of any home or other renovations. These include, but are not limited to, hospital beds, bath lifts, commodes eggcrate/gel mattresses and hospital beds which are rented, or purchased when ordered by a doctor.
- mobility devices required to allow increased mobility in and outside the house if medically appropriate. These include, but are not limited to, wheelchair lifts, scooters, rollabout chairs, walkers, casts, splints, canes, crutches and wheelchairs which are medically necessary and are 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 wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the

use of an electric wheelchair. Wheelchair pads and inserts required for use with a chair are also covered.

- braces or trusses required to minimize pain or support part of the body in an appropriate position. These include, but are not limited to, leg or knee braces.
- prosthetics required to replace parts of the body lost due to illness, injury, surgery or malformation at birth or during development. These include, but are not limited to, the purchase and repairs to artificial eyes, legs, arms, breast prosthetics and chin reconstruction. We will also cover wigs following chemotherapy or if hair loss is due to a disease, up to a lifetime maximum of \$500 per person. Wigs do not require a doctor's order.

Other medical services and equipment

We will also cover 100% of the costs for the medical services listed below when ordered by a doctor.

- 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. Expenses incurred outside your province of residence for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- elastic support stockings, including pressure gradient hose.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- surgical brassieres required as a result of surgery.

Paramedical services

We will cover 100% of the costs, up to the maximum for the paramedical specialists listed below:

- licensed speech therapists, up to a maximum of \$200 per person per benefit year
- licensed psychologists – \$15 per half hour for the initial visit and \$15 per visit for subsequent visits, up to a maximum of \$225 per person per benefit year.
- licensed physiotherapists – \$15 per visit, up to a maximum of \$225 per person per benefit year.
- licensed massage therapists, when ordered by a doctor – \$15 per visit, up to a maximum of \$225 per person per benefit year.
- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, podiatrists or chiropodists – \$15 per visit, up to a maximum of \$225 per person per benefit year per practitioner. Also included is one x-ray examination per specialty each benefit year.
- licensed naturopaths – \$15 per visit, up to a maximum of \$225 per person per benefit year.
- licensed Christian Science Practitioner – \$15 per visit, up to a maximum of \$225 per person per benefit year.

**Contact lenses,
eyeglasses or laser
eye correction
surgery
(for the retiree only)**

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery. Contact lenses or eyeglasses 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 \$150 per retiree for one purchase every 24 months. If a period of three years passes between any claim for vision care, we will provide a maximum of up to \$200 towards the purchase. No coverage exists for dependents.

We will also cover 100% of the costs for the initial purchase of prescription glasses if required as the result of an accident when prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician.

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. Repairs to eyeglass frames are also excluded.

What is not covered We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and 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 and humidifiers).
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. Experimental or investigational treatments mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- 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.

**Integration with
government
programs**

- participation in a criminal offence.

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 Human Resources Representative at McMaster University.

In order for you to receive benefits, we must receive a claim at the earlier of:

- prior to September 30th following the end of the benefit year (July 1 to June 30) in which the claims were incurred, or
- the end of your Extended Health Care coverage.

Dental Care

Plan administrator	<i>This benefit is administered by Sun Life Assurance Company of Canada on behalf of McMaster University.</i>
General description of the coverage	<p>The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.</p> <p>In this section, <i>you</i> means the retiree and all dependents covered for Dental Care benefits.</p> <p>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.</p> <p>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 of the province of Ontario, regardless of where the treatment is received.</p> <p>If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then 120% of the fee guide approved by the Ontario Dental Association for that specialist will be used.</p> <p>When a fee guide is not published for a given year, the term <i>fee guide</i> may also mean an adjusted fee guide established by Sun Life.</p> <p>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.</p>

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 July 1 to June 30.

Deductible

There is no deductible for this coverage.

Emergency expenses out of your province of residence

Expenses incurred for emergency dental services out of your province of residence are eligible if:

- they represent the usual, customary and reasonable charges for the procedures in the locality where they are performed, and
- charges for such procedures would be paid under this policy had the procedures been performed in your province of residence, or if you do not reside in Canada, in the province of the place of issue.

For expenses incurred for other than emergency dental services out of your province of residence, but within Canada, we will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners of the province of Ontario, regardless of where the treatment is received.

Predetermination

We suggest that you send Sun Life an estimate, before the work is

done, for any major treatment or any procedure that will cost more than \$500. You should send Sun Life 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. Sun Life 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 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 48 months.

1 recall examination, limited to one examination every 6 months for children under 14 or every 9 months for any other person.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 48 months.

1 set of bitewing x-rays every 9 months.

Periapical radiographs.

Interpretation of radiographs received from another source.

Cephalometric radiographs.

Occlusal films.

Extra oral films.

Sinus examination.

Sialography.

Use of radiopaque dyes to demonstrate lesions.

Temporomandibular joint films - minimum four films.

Duplicate radiographs.

Tomography.

Hand and Wrist (as diagnostic aid for dental treatment).

Tests and laboratory examination.

Other services Polishing (cleaning of teeth) and topical fluoride treatment, limited to one treatment every 6 months for children under 15 or every 9 months for any other person.

Emergency or palliative services.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants, but not more than once to the biting surface of the first permanent molar teeth for children under 9 or once to the biting surface of the second permanent molar teeth for children under 15, limited to once per tooth per person's lifetime.

Oral hygiene instruction.

Nutritional counselling.

Finishing restorations, including removal of overhangs, refining of marginal ridges and occlusal surfaces when restorations were performed by another dentist or restorations are more than two years old.

Mouthguards (other than those intended for sport use).

Basic dental procedures

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

We will pay 85% of the eligible expenses for these procedures.

Fillings Amalgam, composite, acrylic or equivalent.

Extraction of teeth Removal of teeth.

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.

Oral surgery Surgery and related anaesthesia.

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

Other services Professional consultation.

Major dental procedures

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

We will pay 70% of the eligible expenses for these procedures, up to a maximum of \$2,000 per person for each benefit year.

Major restorations Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Please see the Basic Dental Procedures section for prefabricated metal restorations coverage*).

Repair Repair of bridges or dentures.

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.

We will pay 50% of the eligible expenses for these procedures, up to a maximum amount of \$2,000 in a covered person's lifetime.

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 (*Please see the Preventive dental procedures section for space maintainers*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

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).
- 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.
- participation in a criminal offence.

**When and how to
make a claim**

To make a claim, complete the claim form that is available from McMaster University. The dentist will have to complete a section of the form. Claims may be submitted electronically for some expenses. Please contact your Human Resources Representative at McMaster University for more information.

In order for you to receive benefits, we must receive a claim at the earlier of:

- prior to September 30th following the end of the benefit year (July 1 to June 30) in which the claims were incurred, 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

Insurer	<i>This benefit is insured by Sun Life Assurance Company of Canada for the contract holder Council of Ontario Universities.</i>
General description of the Life coverage	Your Life coverage provides a benefit for your beneficiary if you die while covered.
Life coverage for you	
<i>Amount</i>	Your Life benefit is \$5,000. Eligible members who retire on or after July 1, 1997, may elect at retirement to retain your Basic Life coverage in force immediately prior to retirement until age 65. On the first of the month coincident with or next following the date you reach age 65, coverage will reduce to \$5,000.
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. A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to

designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Converting Life coverage

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

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

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact McMaster University 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 Human Resources Representative at McMaster University.

Respecting your privacy

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

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

