

your **group**
benefits

McMaster University

The Management Group (TMG)

**Contract Number 10334, 25018 & 50813
Effective July 1, 2022**

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McMaster University is pleased to provide The Management Group (TMG) members with a comprehensive outline of the University sponsored benefit programs.

As a member of The Management Group (TMG), you may be eligible for Extended Health Care, Dental Care, Group Life, Long-Term Disability and Emergency Travel Assistance as a benefit of your employment with McMaster University.

You must be enrolled in the Extended Health Care plan in order to be eligible to participate in the Emergency Travel Assistance benefit. The Extended Health Care benefit is provided in combination with the provincial health care plan in order to protect both you and your dependents against the cost of a wide range of medically necessary services and supplies. To be eligible for coverage under the Extended Health and Dental Care plans with Sun Life, you must be covered under your provincial health care plan. For further information on your provincial health care, please contact your local provincial health care office.

This booklet is supplied by Sun Life, and contains detailed coverage information for the benefits provided through them.

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 (TELUS Health Solutions RX05 Formulary in effect)
<i>Drug substitution limit</i>	Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.
<i>Convalescent hospital</i>	100%, of the difference between the cost of a ward and a semi-private room, up to \$20 per day for a maximum of 120 days in a benefit year

<i>Out-of-province emergency services</i>	100% Emergency Travel Assistance included Maximum of 60 days per trip Lifetime maximum of \$3,000,000 per person for out-of-Canada services
<i>Out-of-province referred services</i>	80% Lifetime maximum of \$10,000 per person for out-of- province services
<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
<i>Ambulance services</i>	100%
<i>Tests and services</i>	100%
<i>Hearing aids</i>	80% of the costs of hearing aids, up to a maximum of \$1,000 per person per ear over a period of 3 benefit years. 100% of the costs of the initial purchase of a hearing aid, 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, 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%

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 \$500 per person per a benefit year.
- licensed physiotherapists, up to a maximum of \$500 per person per benefit year.
- licensed massage therapists, up to a maximum of \$500 per person per benefit year.
- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, podiatrists or chiropodists, up to a maximum of \$500 per person per benefit year per practitioner. Also included is one x-ray examination per specialty each benefit year.
- licensed naturopaths, up to a maximum of \$500 per person per benefit year.
- licensed occupational therapists, up to a maximum of \$500 per person per benefit year.

We will also cover 100% of the costs, up to a combined maximum of \$3,000 per person per benefit year for all paramedical specialists listed below:

- licensed psychologists or social workers.
- licensed psychotherapists, or psychotherapists who are active members of a provincial association approved by Sun Life.
- clinical counsellors who are active members of a provincial association approved by Sun Life.
- licensed marriage or family therapists, or marriage or family therapists who are active members of a provincial association approved by Sun Life.
- psychoanalysis treatment, which must be performed by a psychoanalyst who has undergone appropriate training and obtained the necessary credentials recognized by Sun Life.

Vision care – Contact lenses, eyeglasses or laser eye correction surgery We will cover 100% of these costs up to a maximum of \$500 per person in any 24 month period.

Vision care – eye examinations 100%, up to a maximum of one eye exam and \$100 per person every 2 benefit years

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	
<i>Preventive procedures</i>	100%
<i>Basic procedures</i>	85%
<i>Major procedures</i>	70%
<i>Orthodontic procedures</i>	50%
Maximum benefit	
<i>Benefit year maximum</i>	Major procedures – \$2,500 per person
<i>Lifetime maximum</i>	Orthodontic procedures – \$2,500 per person

Health Spending Account – 25018

<i>Benefit year</i>	July 1 to June 30
Credits	\$500 at the beginning of each benefit year
	If your coverage starts after the benefit year begins, your credits are adjusted based on the number of days remaining in that benefit year
Eligible expenses	Expenses that are considered eligible medical expenses under the Income Tax Act (Canada)

Long-Term Disability – 10334

Maximum amount	75% of your monthly net income up to a maximum of \$7,000 The maximum amount may be reduced by income provided from other sources as described in the <i>Long-Term Disability</i> section of this booklet	
Elimination period	Employee's length of employment:	Elimination period:
	6 months but less than 5 years	15 weeks

5 years but less than 10 years 18 weeks

10 years or more 26 weeks

Termination June 30th following the day you reach age 65 less the elimination period or the day you retire, whichever is earlier

Life – 50813***Employee Basic Life***

Amount An amount equal to your annual basic earnings, rounded to the next higher \$1,000 (if not already a multiple of \$1,000), subject to the maximum insurable annual basic earnings of \$100,000 multiplied by 175%
Maximum – \$175,000

Termination The last day of the month in which you retire or December 1st of the year you reach age 69, whichever is earlier

Employee Optional Life

Amount An amount equal to your annual basic earnings, rounded to the next higher \$1,000 (if not already a multiple of \$1,000), subject to the maximum insurable annual basic earnings of \$100,000 multiplied by increments of 25% up to 1000% inclusive
Maximum – \$1,000,000

Proof of good health Required on all optional amounts of coverage

Termination The last day of the month in which you retire or December 1st of the year you reach age 69, whichever is earlier

Accidental Death and Dismemberment – 50813***Employee Optional Accidental Death and Dismemberment***

Amount You can choose coverage in units of \$10,000
Maximum – \$500,000

Termination When you retire or reach age 80, whichever is earlier

Dependent Optional Accidental Death and Dismemberment

Amount

Spouse only – 60% of the employee's Optional Accidental Death and Dismemberment Insurance amount.

Spouse with Children – 50% of the employee's Optional Accidental Death and Dismemberment Insurance amount.

Child only – 20% of the employee's Optional Accidental Death and Dismemberment Insurance amount for each child.

Child with Spouse – 15% of the employee's Optional Accidental Death and Dismemberment Insurance amount for each child.

Termination

When you retire or reach age 80, whichever is earlier

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 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, McMaster University, self-insures the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Health Spending Account

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. All other benefits are insured by Sun Life.

Eligibility

To be eligible for group benefits, you must:

- be a resident of Canada.
- be enrolled in your provincial health care plan, and
- hold an appointment within The Management Group for a minimum duration of twelve (12) months or more.

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 scheduled period of paid vacation 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 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 enrol for coverage for yourself in order for your dependents to be eligible.

Eligibility for Long-Term Disability

Premiums for the Long Term Disability (LTD) Plan are employee paid. Participation in the LTD Plan is mandatory for employees in permanent appointments, or in contractual appointments of one year's duration or more; excluding clinical faculty members, postdoctoral fellows, clinical fellows, eastburn fellows, research fellows, teaching fellows, conversational assistants and those whose collective agreement preclude enrolment in this plan (i.e., hourly employees). For further information please contact your Human Resources representative or visit <https://hr.mcmaster.ca>.

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.

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 twelve (12) months, is an eligible dependent. You can only cover one spouse at a time.

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

- 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. 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.

Please see your employer for the appropriate enrolment forms.

If you refuse both Extended Health Care and Dental Care coverage under this plan, you will not be entitled to the Health Spending Account coverage.

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.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

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 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.
- overage 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 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.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.
- the date you retire. McMaster University provides eligible retirees with a comprehensive post-retirement benefits package. To find out if you are eligible please contact your Human Resources representative.

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 employee benefits booklet.

However, if you die while covered by this plan, Extended Health Care and Dental Care coverage for your dependents will continue based on whether you participate in the Group RRSP or Pension Plan as follows:

If you participate in the Group RRSP:

- coverage will continue for one year after the date of your death (subject to any applicable co-pay costs) and, thereafter, coverage may be renewed annually for a maximum of four additional years at the cost of the surviving dependent.

If you participate in the Pension Plan:

- if you are under the age of 55, coverage will continue for one year after the date of your death and, thereafter, coverage may be renewed annually for a maximum of four additional years at the cost of the surviving dependent.
- if you are age 55 or older but are not eligible for an immediate unreduced pension, coverage will continue as long as the person would be considered a dependent if you were still alive if the dependent chooses the monthly pension option. If your dependent chooses the lump sum pension option, coverage will continue for one year after the date of your death and, thereafter, coverage may be renewed annually for a maximum of four additional years at the cost of the surviving dependent.
- if you are eligible for an immediate unreduced pension and are eligible for post-retirement benefits, coverage will continue as long as the person would be considered a dependent if you were still alive, regardless of which pension option was chosen.
- if you are eligible for an immediate unreduced pension and are not eligible for post-retirement benefits, coverage will continue for one year after the date of your death and, thereafter, coverage may be renewed annually for a maximum of four additional years at the cost of the surviving dependent.

Continuation of coverage will end on the date that any benefit provision

under which the dependent is covered terminates.

For the Optional Dependent Accidental Death and Dismemberment benefit, coverage will continue without further payment of premiums, subject to all other terms of this policy until the earlier of the following dates:

- 6 months after the date of your death.
- 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 date of termination of the policy.

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.

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. 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

Every action or proceeding against the 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* (Ontario) or other applicable statute.

Legal actions for self-insured benefits

Every action or proceeding against the insurer or employer for recovery of money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002* (Ontario) or other applicable statute.

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 number (25018) and certificate number (employee ID number), which are shown on your Sun Life card should be provided. You may also email 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 coverages for Life, Long-Term Disability or the Emergency Travel Assistance benefit, please contact your Human Resources representative.

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

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.

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.

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

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

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

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

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

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

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

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

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

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

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.

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

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

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

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

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

Definitions Here is a list of definitions of some terms that appear in this 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 or overtime pay.

For the Life coverage, if you are on a pre-retirement reduced work load, basic earnings will be based on your full-time earnings as defined above.

For the Life coverage, if you are on a general reduced work load, basic earnings will be prorated according to your reduced earnings for the duration of your participation in the reduced workload program.

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

<i>Illness</i>	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.
<i>Normal retirement age</i>	The normal retirement age is the 30th day of June coincident with or next following the date you attain age 65.
<i>Retirement date and disability</i>	If you are totally disabled, your retirement is the date you attain the normal retirement age, unless you have actually retired before then.
<i>We, our and us</i>	We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care (Medicare Supplement)

**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 Extended Health Care benefits.

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *Medically necessary* 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.

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

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

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

The benefit year is from July 1 to June 30.

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.

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

Prescription drugs

We will cover 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.

- selected drugs and supplies that are therapeutically useful and cost effective, and listed in the TELUS Health Solutions RX05 Formulary. Approved new brand name drugs and generic drugs where the brand name drug is eligible under this plan will be added on a regular basis.
- vaccines that legally require a prescription.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- intrauterine devices (IUDs) and diaphragms.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$500 for each person.
- colostomy supplies.
- varicose vein injections.

We will cover 100% of 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.

***Drug substitution
limit***

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

***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 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.

**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.
- 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 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.

*Coverage is no longer available to dependents effective December 1st of the year the employee reaches age 69.

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.

***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.

Referred services out of your province Expenses incurred for referred 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.

Emergency services outside Canada Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of \$3,000,000 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 cannot 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 of 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 80% of the costs of hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$1,000 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 chiroprapist, 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.
- 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.

- 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.
- 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.

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 employee lives. The guide must be the current guide at the time that treatment is received.
- elastic support stockings, including pressure gradient hose.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, up to a combined maximum of \$4,000 per person per benefit year. You must provide us with a doctor's note confirming the diagnosis.
- 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 \$500 per person per benefit year.
- licensed physiotherapists, up to a maximum of \$500 per person per benefit year.
- licensed massage therapists, up to a maximum of \$500 per person per benefit year.
- licensed osteopaths (this category of paramedical specialists also includes osteopathic practitioners), chiropractors, podiatrists or chiropodists, up to a maximum of \$500 per person per benefit year per practitioner. Also included is one x-ray examination per specialty each benefit year.
- licensed naturopaths, up to a maximum of \$500 per person per benefit year.
- licensed occupational therapists, up to a maximum of \$500 per person per benefit year.

We will also cover 100% of the costs, up to a combined maximum of \$3,000 per person per benefit year for all paramedical specialists listed below:

- licensed psychologists or social workers.
- licensed psychotherapists, or psychotherapists who are active members of a provincial association approved by Sun Life.
- clinical counsellors who are active members of a provincial association approved by Sun Life.
- licensed marriage or family therapists, or marriage or family therapists who are active members of a provincial association approved by Sun Life.
- psychoanalysis treatment, which must be performed by a

Contact lenses, eyeglasses or laser eye correction surgery

psychoanalyst who has undergone appropriate training and obtained the necessary credentials recognized by Sun Life.

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 \$500 per person every 24 months.

We will also cover 100% of the following costs:

- 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.
- lenses required as a result of cataract surgery, up to a maximum of \$250 per eye.

We will also cover the services of an ophthalmologist or licensed optometrist, limited to one eye exam over 2 benefit years, up to a maximum of \$100 per person.

We will not pay for sunglasses or magnifying glasses of any kind unless they are prescription glasses needed for the correction of vision. Repairs to eyeglass frames are also excluded.

We will not pay for safety glasses of any kind.

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, 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.
- participation in a criminal offence.

Integration with government programs

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

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

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

When and how to make a claim

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

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

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

Emergency Travel Assistance

**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 Emergency Travel Assistance benefits.

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

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 60* days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

*Coverage is no longer available to dependents effective December 1st of the year the employee reaches age 69.

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

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

Getting help

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

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

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

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

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

**Limits on
Emergency Travel
Assistance coverage**

There are countries where Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure.

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

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

**Liability of Sun Life
or Allianz Global
Assistance**

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

Dental Care

**General description
of the coverage**

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 of the province of Ontario, regardless of where the treatment is received.

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 the fee guide approved by the provincial Dental Association for that specialist will be used.

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

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

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure 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.

Expenses out of your province of residence

For expenses incurred for non-emergency dental services out of your province of residence, 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 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 48 months.

1 recall examination, limited to one examination every 6 months for children under 15 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, limited to 1 treatment per permanent tooth.
Only children under 18 are covered for this treatment.

Oral hygiene instruction.

Nutritional counselling.

Finishing restorations, including removal of overhangs, refining of marginal ridges and ocular 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 and implant related surgery (*Major dental procedures*).

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 \$2,500 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.

Implants

Implants, including surgery charges, subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant.

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 \$2,500 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.

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.

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- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
 - transplants and repositioning of the jaw.
 - experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form. Claims may be submitted electronically for some expenses. Please contact your employer for more information. Assignment of dental claims to the dental office is allowed, whenever such service is available.

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 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.

Health Spending Account

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.

Your Health Spending Account coverage pays for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependent is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

The benefit year is from July 1 to June 30.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one benefit year cannot be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year following the benefit year in which they have been allocated to your

account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Continuation of coverage for dependents

The Health Spending Account is set up under the employee's name, and there cannot be any continuation of coverage for dependents after the employee's death. Only expenses incurred before the employee's death can be covered under the employee's Health Spending Account.

Plan credits

\$500 on the commencement of each benefit year

If your coverage starts after the commencement of the benefit year, your plan credits are adjusted based on the number of days remaining in that benefit year.

Eligible expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act (Canada) **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act (Canada) is changed, this plan is automatically updated to reflect the changes.

Drugs ■ drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses ■ eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances ■ deductible and coinsurance amounts under medical or dental plans.

-
- | | |
|--|---|
| <i>Licensed practitioners
(fee for services)</i> | <ul style="list-style-type: none">■ acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapists. |
| <i>Dental care</i> | <ul style="list-style-type: none">■ preventative, diagnostic, restorative, orthodontic and therapeutic care. |
| <i>Attendant care</i> | <ul style="list-style-type: none">■ remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.■ remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration. |
| <i>Facilities</i> | <ul style="list-style-type: none">■ amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.■ payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements. |
| <i>Hospitals</i> | <ul style="list-style-type: none">■ payments to a public or licensed private hospital. |
| <i>Devices and supplies</i> | <ul style="list-style-type: none">■ artificial eyes.■ artificial limbs. |

- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of \$1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.

- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.

- oxygen tent or equipment.
 - power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
 - rocking bed for poliomyelitis victims.
 - spinal braces.
 - teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
 - truss for a hernia.
 - walkers.
 - wheelchairs.
 - wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.
- Other*
- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
 - costs of medical services and supplies outside of the province of residence.
 - diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.

- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
 - equivalent medical services are not available locally.
 - the route is reasonably direct.
 - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

If you or your eligible dependents have coverage under another plan, you should submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

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 Health Spending Account coverage.

Long-Term Disability

Please see the General Information section of this booklet for eligibility details.

General description of the coverage

Long-Term Disability coverage provides a benefit to you if you are totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you have been under the continuous care of a doctor for the disability since its onset.

For your Long-Term Disability coverage,

- during the elimination period and the following 24 months (this period is known as the own occupation period), you will be considered totally disabled while you are continuously unable due to an illness to do each and every duty of your normal occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

Benefits are paid at the end of each month and are based on your coverage on the date you became totally disabled.

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period as shown below or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later. Your employer can provide you with further information on the Salary Continuance Plan.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for at least the elimination period and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

Employee's length of employment	Elimination period
6 months but less than 5 years	15 weeks
5 years but less than 10 years	18 weeks
10 years or more	26 weeks

What we will pay

Here is how we calculate your Long-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take 75% of your monthly net income, up to a maximum of \$7,000.

Net Income is your monthly basic earnings reduced by income tax, Québec/Canada pension plan contributions and Employment Insurance premiums. This calculation will be based on the assumption that you have a spouse.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment

insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.

- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind.
- under a retirement or pension plan funded in whole or in part by the employer.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.
- any amount of income provided for you from any employer by reason of the same or subsequent disability, other than cost of living adjustments provided by the employer.
- under the Québec Parental Insurance Plan.

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.

We will not take into account any benefits that began before your disability began. The following will not be considered as income under this plan:

- any amount of income provided for you under any Workers' Compensation Disability Pension which you were receiving on the date you became totally disabled.
- payments under any accidental death and dismemberment plan of the employer.

We have the right to adjust your benefit payments when necessary.

Your Long-Term Disability payment will be increased in January of each year to reflect the average increase, if any, in the Canadian Consumer Price Index over the 12 month period ending 3 months prior to the date of any adjustment. Any percentage increase to your benefit payment cannot exceed 2%. In the event of deflation, we will not decrease your benefit payment.

**Maternity / parental
leave of absence**

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period equal to the elimination period indicated above, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

It may include the involvement of our rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long-Term Disability payments plus income from other sources. However, if during any month your total income is more than 100% of your pre-disability disposable income as determined by the employer, indexed for inflation, your Long-Term Disability payments will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled. If you enter a rehabilitation program during the elimination period, it will not be considered an interruption of the elimination period.

Your participation in a rehabilitation program will be limited to the own occupation period.

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and all of the following conditions are met:

- the initial period of total disability lasts for at least 30 days without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the elimination period.

If the Long-Term Disability benefit terminates, any balance of the elimination period must subsequently be completed by uninterrupted total disability.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 6 months of the end of your previous disability. You must be covered when total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability.

Your responsibilities

During your total disability, you must make reasonable efforts to:

- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.

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- return to your own occupation during the first 24 months that benefits are payable.
 - obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
 - try to obtain work in another occupation after the first 24 months that benefits are payable.
 - obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

When payments end Your Long-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- June 30th following the date that you reach age 65.
- the last day of the month in which you die.

When coverage ends Long-Term Disability coverage will end on June 30th following the day you reach age 65 less the elimination period or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends If the Long-Term Disability plan terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the plan were still in effect.

What is not covered We will not pay benefits for any period:

- you are not under the continuous care of a doctor.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not receiving appropriate treatment.

- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under Maternity / parental leave of absence or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries.
- participation in a criminal offence.

When and how to make a claim

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

We must receive notice of claim on the earlier of the following dates:

- 30 days before the end of the elimination period or, if later, within 6 months after the total disability begins.
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give us as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, we must receive these forms no later than 90 days after the end of the elimination period.

We will assess the claim and send you or your employer a letter outlining our decision.

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 this request, you will not be entitled to benefits.

Life Coverage

Insurer	This benefit is insured by Sun Life Assurance Company of Canada for the contract holder Council of Ontario Universities.
Note:	<p>The Group Life Insurance Plan as outlined below applies to employees hired by McMaster University since January 1, 1996 or to those hired prior to this date who opted to participate in this plan. The Basic Group Life Insurance plan is provided as a benefit of your employment. Employees may choose to participate in Optional Group Life Insurance plan, and are responsible for the cost of this benefit. The premiums are payable through bi-weekly payroll deductions.</p> <p>The “old” or “grand-fathered” Group Life Insurance Plans (entered into prior to January 1, 1996) are not described in this booklet. For further information please contact your Human Resources representative or visit https://hr.mcmaster.ca.</p>
General description of the Life coverage	Your Life coverage provides a benefit for your beneficiary if you die while covered.
Basic Life coverage for you	
<i>Amount</i>	Your Life benefit is an amount equal to your annual basic earnings, rounded to the next higher \$1,000 (if not already a multiple of \$1,000), subject to the maximum insurable annual basic earnings of \$100,000 multiplied by 175% subject to the maximum benefit of \$175,000.
<i>Coverage ends</i>	<p>Your coverage will end on the last day of the month in which you retire or December 1st of the year you reach age 69, whichever is earlier. However, if you are eligible for post-retirement benefits you will receive a Life Insurance benefit in the amount of \$5,000. Coverage may also end on an earlier date, as specified in <i>General Information</i>.</p> <p>If you retire prior to the normal retirement age of 65, you <u>may be eligible</u> to continue a portion of your life coverage. Please contact your Human Resources representative to confirm your eligibility.</p>

Optional Life coverage for you

You must pay the cost of this coverage. Optional life rates are subject to change. Please see your Human Resources representative for current rates.

Amount Your Optional Life benefit is an amount equal to your annual basic earnings, rounded to the next higher \$1,000 (if not already a multiple of \$1,000), subject to the maximum insurable annual basic earnings of \$100,000 multiplied by increments of 25% up to 1000% inclusive subject to the maximum benefit of \$1,000,000.

Proof of good health Required on all optional amounts of coverage.

Coverage ends Your coverage will end on the last day of the month in which you retire or December 1st of the year you reach age 69, whichever is earlier. 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.

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.

**Coverage during
total disability
(Optional Only)**

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:

- an uninterrupted period of 6 months before Sun Life will assess your proof of disability, or
- the elimination period for Long-Term Disability if you are entitled to Long-Term Disability payments, whichever is shorter.

If your proof of total disability is approved by Sun Life, 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.

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. However, if you are totally disabled under the Long-Term Disability benefit, you are also considered to be totally disabled under the Life benefit.

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.

Written application must be made to Sun Life, accompanied by the first premium no later than 31 days after coverage ends or is reduced. This is called the 31 day conversion period.

You may choose an individual plan with equivalent coverage to the coverage which terminated or reduced under your plan, but without disability benefits. If equivalent coverage is not provided under an individual plan issued by Sun Life, then Sun Life will offer a plan of equal value. You may instead choose any other individual policy which Sun Life is willing to offer, but without disability benefits.

The amount of individual life insurance will be limited by the following:

- if coverage is terminated or reduced because the group contract is terminated or amended, the amount of a person's individual life insurance policy may not exceed the amount of coverage that is terminated or reduced less any amount of insurance available under another group contract within 31 days.
- if coverage is terminated or reduced for any other reason, the amount may not exceed the amount of coverage that was terminated or reduced.
- if a person is entitled to convert coverage under more than one benefit provision or more than one contract issued by Sun Life to the contract holder, then the sum of the amounts available for conversion under all such benefit provisions cannot exceed \$200,000, or the amount stipulated in any applicable legislation, if greater.
- if a person does not convert the entire amount available for conversion, the individual life insurance cannot be less than the minimum amount which Sun Life issues for the plan selected.
- the premium rate for the individual policy will be based on Sun Life's rate for the sex, plan and age of the person on the effective date of the individual policy. If requested and the person applying for the insurance is under age 66, the premium

rate for the first year will be that of a one year term policy, but the premium rates after the first year will be based on the original age plus one. If an extra premium had been applied to the group premium, then a comparable extra premium may be applied to the individual contract issued as a result of conversion.

- the effective date of the individual policy will be the day following the end of the 31 day conversion period.
- if, after the conversion, a person is insured within 6 months under any Sun Life group contract with the contract holder, the amount of coverage under the group contract will be limited to the amount of the person's coverage under the group contract minus any amount still in effect under the individual life insurance policy.

31 Day Free Cover: When Sun Life receives proof of claim that a person has died during the 31 day conversion period, Sun Life will pay the amount of coverage eligible for conversion, or the amount stipulated in any applicable legislation, if greater.

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.

Accidental Death and Dismemberment

Insurer	This benefit is insured by Sun Life Assurance Company of Canada for the contract holder Council of Ontario Universities.
General description of the coverage	Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you or one of your dependents die or suffer any of the losses listed in the table under <i>What we will pay</i> . Any death benefit paid under this coverage is in addition to the Life coverage.
Optional accidental coverage for you	
<i>Amount</i>	You can choose coverage in units of \$10,000. The maximum amount of coverage is \$500,000.
<i>Coverage ends</i>	Your coverage will end when you retire or reach age 80, whichever is earlier. Coverage may also end on an earlier date, as specified in <i>General Information</i> .
Optional accidental coverage for your dependents	
<i>Amount</i>	Spouse only – 60% of the employee's Optional Accidental Death and Dismemberment Insurance amount. Spouse with Children – 50% of the employee's Optional Accidental Death and Dismemberment Insurance amount. Child only – 20% of the employee's Optional Accidental Death and Dismemberment Insurance amount for each child. Child with Spouse – 15% of the employee's Optional Accidental Death and Dismemberment Insurance amount for each child.
<i>Coverage ends</i>	Coverage for your dependents will end when you retire or reach age 80, whichever is earlier. Coverage may also end on an earlier date, as

specified in *General Information*.

What we will pay

We will pay for this benefit if you or one of your dependents:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you or your dependent are still alive.
- are in an accident or exposed to the elements and, as a direct result, you or a dependent suffer one of the losses listed below within one year of that accident or exposure.

The amount that we will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages we use to determine the payment.

AMOUNT OF BENEFIT FOR EMPLOYEE AND SPOUSE**TABLE OF LOSSES**

Loss of life	100%
Loss of both arms or both legs**	200%
Loss of both hands or both feet	100%
Loss of one hand and one foot	100%
Loss of one hand or one foot, and entire sight of one eye	100%
Loss of one arm or one leg	80%
Loss of one hand or one foot	75%
Loss of four fingers on the same hand	33%

Loss of all toes on the one foot	25%
Loss of use of both arms or both legs or combination of one arm and one leg**	200%
Loss of use of both hands or both feet or a combination of one hand and one foot	100%
Loss of use of one arm or one leg	80%
Loss of use of thumb and index finger on the same hand	33%
Loss of use of one hand or one foot	75%
Loss of thumb and index finger on the same hand	33%
Loss of entire sight of both eyes	100%
Loss of speech and loss of hearing in both ears	100%
Loss of entire sight of one eye	75%
Loss of speech	75%
Loss of hearing in both ears	75%
Loss of hearing in one ear	33%
Quadriplegia**	200%
Paraplegia**	200%
Hemiplegia**	200%

**Subject to a maximum of \$1,000,000 per person.

If an employee or spouse has multiple losses as a result of one accident, the maximum amount payable shall not exceed 100% of the loss of life benefit amount with the exception of loss of use of both arms, both legs or a combination of one arm and a leg, quadriplegia, paraplegia and hemiplegia. In no event will the maximum benefit amount exceed 200%.

ENHANCED CHILD BENEFIT**TABLE OF LOSSES**

Loss of life	100%
Loss of both arms or both legs	100%
Loss of both hands or both feet	400%
Loss of one hand and one foot	400%
Loss of one hand or one foot, and entire sight of one eye	400%
Loss of one arm or one leg	200%
Loss of one hand or one foot	200%
Loss of four fingers on the same hand	33 1/3%
Loss of four toes on the same foot	50%
Loss of use of both arms or both legs	400%
Loss of use of both hands or both feet	400%
Loss of use of one arm or one leg	200%
Loss of use of thumb and index finger on the same hand	50%
Loss of use of one hand or one foot	150%
Loss of thumb and index finger on the same hand	33 1/3%
Loss of entire sight of both eyes	400%
Loss of speech and loss of hearing in both ears	400%
Loss of entire sight of one eye	200%

Loss of speech	100%
Loss of hearing in both ears	100%
Loss of hearing in one ear	25%
Quadriplegia	400%
Paraplegia	400%
Hemiplegia	400%

Quadriplegia, paraplegia and hemiplegia will become payable after the elimination period of 365 days has been satisfied.

Loss of an arm means severance at or above the elbow. Loss of a leg means severance at or above the knee. Loss of a hand means severance at or above the wrist. Loss of a foot means severance at or above the ankle. Loss of a thumb, finger or toe means severance at or above the first phalange. Loss of sight, loss of speech or loss of hearing must be total and irrecoverable.

Loss of use must be total, continuous for 12 months, and then must be determined to be permanent and irrecoverable before the benefit is payable.

Repatriation benefit

When loss of life results in an amount of benefit becoming payable under this benefit, a Repatriation Benefit will also be payable, as follows:

- payment is made if within 1 year of the accidental bodily injury, and
- the loss of life must occur at least 50 kilometres away from the residence of the deceased Employee,

The maximum amount payable is \$15,000.

Rehabilitation benefit

Rehabilitation/retraining means the Reasonable and Customary charges for treatment by a therapist licensed, registered or certified to provide such treatment or confinement in an institution which is licensed to provide such treatment; where treatment is intended to retrain the insured person for work in any gainful occupation including the employee's regular occupation.

Must take place under the direction of a certified vocational rehabilitation specialist.

Benefit will be paid if an accidental bodily injury prevents the employee from performing the duties of the employee's regular occupation and requires the employee to obtain rehabilitation/retraining as determined by a physician approved by the company.

Benefits will be paid until one of the following occurs:

- the total rehabilitation/retraining benefit has been paid; or
- two years have elapsed from the date of the accidental bodily injury; or
- the employee dies.

The maximum amount payable is \$15,000.

Spouse occupational training benefit

Spouse employment training expenses means the actual incurred costs for tuition, fees, and room and board billed by the institution of higher learning. Also means the costs for required books and required course supplies. These costs must be incurred for the Employee's spouse to attend an institution of higher learning for the purpose of obtaining or refreshing skills needed for employment. Benefit is payable only if the spouse incurs expenses within 3 years following the date of the employee's loss of life. Participant must have elected spousal coverage under the policy.

The maximum amount payable is \$15,000.

Child education benefit

Education means the actual incurred costs for tuition, fees, room and board billed by the institution of higher learning for the education of the employee's dependent children. Also means costs for required books and required course supplies. Child must be enrolled as a full time student at an institution of higher learning on the date of the insured person's loss of life or subsequently enrol as a full time student at an institution of higher learning within 2 years following the date of the Employee's loss of life. Payments also limited to 4 consecutive years for each dependent child. Institution of higher learning means any public or private college, university or professional trade school beyond the 12th grade. Participant must have elected coverage for dependent children under the policy.

The maximum amount payable is \$7,500 per year, \$30,000 total benefit payment.

Family transportation benefit

Insured person must be confined to a hospital no less than 50 kilometres from his permanent city of residence and the attending physician recommends the personal attendance of a member of the immediate family. Sun Life standard rate of \$0.20 per kilometre applies. Member of the immediate family means the spouse, parents, grandparents, children age 18 and over, brother or sister of the insured person.

The maximum amount payable is \$15,000.

Child Care expenses

The actual incurred costs billed by the provider for the care and supervision of the insured person's dependent children under the age of 13. Expenses must be incurred within 365 days of the loss of life. If on the date of the insured person's loss of life the dependent children are not eligible for child care expenses, a one-time payment of \$2,500 will be made in addition to the loss of life benefit. If this is paid, no additional claims can be made under the child care benefit. Insured person must have elected coverage for dependent children under the policy.

The maximum amount payable is \$5,000 per child per year to a maximum of \$25,000.

Funeral expenses

Funeral expenses means the reasonable costs associated with interment.

The maximum amount payable is \$5,000.

**Home/vehicle
modification benefit**

Alterations to the employee's residence that are necessary to make the residence accessible and habitable for the employee / Modifications to a private passenger automobile that are necessary to make the automobile accessible and/or driveable by the Employee. Within 2 years of the accidental bodily injury a physician must certify that a home/vehicle adaptation is needed to accommodate the physical disability of the employee and the home/vehicle adaptation is performed by individuals experienced in such adaptation and the home/vehicle adaptation is in compliance with any applicable laws or requirements for approval by appropriate government authorities. Private passenger automobile means a four-wheeled motor vehicle with a maximum capacity of 9, designed, manufactured and registered as a private passenger vehicle to travel on public roads.

The maximum amount payable is \$15,000.

**Identification
expenses**

Identification expense means the actual costs for hotel accommodation for a maximum of 3 days and transportation by a member of the immediate family by the most direct route by a licensed common carrier. Loss of life must occur no less than 50 kilometres from the insured person's permanent city of residence and identification of the body by a member of the immediate family has been requested by the police or a similar government authority.

The maximum amount payable is \$5,000.

Parent care

Dependent parent: parents or grandparent of an employee or spouse who at the time of an accident is receiving support and care provided by such employee or spouse as evidenced by Canadian income tax returns showing parent as a dependent.

The maximum amount payable is \$5,000 per eligible parent.

Psychological therapy

Psychological therapy means the reasonable and customary charges for treatment or counselling by a therapist or counsellor, who is licensed, registered or certified to provide such treatment whether on an outpatient basis or while at a medical facility licensed to provide such treatment. Must be prescribed by a physician.

Payments will be made until one of the following occurs:

- the total psychological therapy benefit has been paid, or
- two years have elapsed from the date of the accidental bodily injury, or
- the insured person dies.

The maximum amount payable is \$5,000.

Seat belt and occupant protection device

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the Canadian Motor Vehicle Standards administered by Transport Canada and has been installed in accordance with the manufacturer's instructions.

Occupant protection device means either an air bag, which inflates for added protection to the head and chest areas, or any other personal safety restraint system other than a seat belt.

Benefits will be paid if, at the time of the accident, the employee suffers accidental bodily injury resulting in a loss while:

- operating or riding in a private passenger automobile and utilizing a seat belt.

The seat belt usage and proper operation of the occupant protection device must be verified by a licensed physician, a coroner, a police officer or other person of competent authority.

No benefit is payable if the employee was driving or riding as a passenger in any race or contest of any type, or if intoxicated as defined by laws of the jurisdiction where the accidental bodily injury occurred, or under the influence of a controlled substance unless taken on the advice of a physician and used in accordance with the prescription at the time of the accident.

The maximum amount payable is 10% of benefit amount for seat belt, 10% of benefit amount for occupant protection device to a combined maximum of \$50,000.

Vocational training

Vocational training expenses means the actual costs incurred for tuition, fees, room and board billed by an institution of higher learning that is intended to prepare an insured person for work in any gainful occupation. Includes costs for required books or course supplies.

Gainful occupation means an occupation including self-employment that is or can be expected to provide an employee with an income equal to at least 60% of the employee's monthly earnings within 12 months after the employee's return to work.

Benefits are payable until the earlier of:

- the total benefit has been paid; or
- two years have elapsed from the date of the accidental bodily injury

The maximum amount payable is \$15,000.

Common accident

If a common accident causes the primary employee's and spouse's loss of life, the combined loss of Life benefit amount will be 2 times the larger of the two loss of Life benefit amounts payable. This combined loss of Life benefit amount will not exceed 2 times the employee's benefit amount.

This extension of coverage is applicable only if the employee has elected coverage under the policy for a spouse, such coverage is in effect on the date of the accident, and the employee and spouse are survived by a dependent child or children to whom the common accident benefit amount can be paid.

Common accident means a single accident or separate accidents that occur within the same 24 hour period and result in accidental bodily injury to an insured person and the insured person's spouse.

The common accident extension of coverage is subject to a maximum amount of 2 times the Employee's loss of life benefits amount.

Aggregate limit

An employee or dependent who has multiple losses as a result of one accident, the maximum amount payable shall not exceed 100% of the loss of Life benefit amount with the exception of loss of use of both arms, both legs or a combination of one arm and a leg, quadriplegia, paraplegia and hemiplegia.

In no event will the maximum benefit amount exceed 200%.

Disability benefit

If a totally disabled employee's insurance is continued by Sun Life before the employee retires or reaches age 65, whichever is earlier, this benefit may continue without payment of premiums under the Optional Accidental Death and Dismemberment Insurance Benefit Provision as long as the employee is totally disabled.

The Amount of Insurance is subject to the terms and conditions of this policy in effect on the date of onset of total disability, including reductions or terminations.

Sun Life requires evidence of the employee's total disability within 12 months of the date the total disability begins. After that, we can require ongoing evidence that the employee continues to be totally disabled.

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

This Disability Benefit ends on the earlier of:

- the date the employee attains age 65,
- the date the employee ceases to be totally disabled,
- the date the employee fails to give Sun Life proof of continued total disability,
- the date the employee's Optional Accidental Death and Dismemberment Insurance Benefit ends.

For the purposes of the Optional Accidental Death and Dismemberment Insurance Benefit, an employee is totally disabled if he is prevented by Illness from performing the duties of his own occupation and does not engage in any occupation or employment for wage or profit.

Converting coverage If an employee's Optional Accidental Death and Dismemberment Insurance terminates or reduces for any reason other than solely as a result of the employee's request, and if he applies for an individual life insurance policy under the terms of the Conversion of the Employee Life Insurance Benefit Provision, the employee is entitled at that time to have an Accidental Death Benefit provision attached to that individual life insurance policy without evidence of insurability, subject to Conditions Of Conversion.

The amount of the Accidental Death Benefit Provision will not be more than \$100,000.

What is not covered A benefit is not paid for a loss which is due to or results from:

- self-inflicted injuries by firearm or otherwise, attempted suicide or suicide regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- drug overdose.
- carbon monoxide inhalation.
- flying in, entering, or exiting any aircraft owned, leased or operated by the employer or any aircraft owned, leased or operated by an employee of the employer on behalf of the employer. This exclusion does not apply to aircraft chartered with pilot or crew on a one time charter basis.
- flying in, entering, or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life threatening emergency.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion
- full-time service in the armed forces of any country.
- commission or attempted commission of a criminal offence
- disease or illness.
- loss caused by or resulting from an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection or bodily malfunction.

This exclusion does not apply to loss resulting from an insured person's bacterial infection caused by an accident or from accidental consumption of a substance contaminated by bacteria.

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).

