Sun Life Financial

# your group benefits

**OPSEU Members who were certified on December 19, 2011**

**Contract Number 101081 and 101121**
**Effective April 1, 2024 (Version 2)**

# Table of Contents

**General Information** ..... **1**
About this booklet ..... 1
Eligibility ..... 1
Who qualifies as your dependent ..... 2
Enrolment ..... 3
When coverage begins ..... 4
Changes affecting your coverage ..... 5
Updating your records ..... 6
Accessing your records ..... 6
When coverage ends ..... 7
Continuation of coverage ..... 7
Replacement coverage ..... 8
Making claims ..... 9
Legal actions ..... 9
Proof of disability ..... 9
Coordination of benefits ..... 9
Medical examination ..... 11
Recovering overpayments ..... 11
Assignments ..... 11
Definitions ..... 11

**Extended Health Care (Medicare Supplement)** ..... **13**
General description of the coverage ..... 13
Deductible ..... 13
Prescription drugs ..... 14
Hospital expenses in your province ..... 18
Medical services and equipment ..... 20
Paramedical services ..... 22
Contact lenses, eyeglasses or laser eye correction surgery ..... 23
When coverage ends ..... 23
Payments after coverage ends ..... 23
What is not covered ..... 24
Integration with government programs ..... 25
When and how to make a claim ..... 25

**Dental Care** ..... **26**
General description of the coverage ..... 26
Deductible ..... 27

Benefit year maximum....27
Lifetime maximum....27
Restriction on payments for late applicants....27
Predetermination....27
Preventive dental procedures....28
Basic dental procedures....29
Major dental procedures....30
Orthodontic procedures....30
When coverage ends....30
Payments after coverage ends....31
What is not covered....31
When and how to make a claim....32

**Health Spending Account....34**
General description of the coverage....34
How your Health Spending Account works....34
Continuation of coverage for dependents....35
Plan credits....35
Eligible expenses....35
When coverage ends....40
Other coverage....40
When and how to make a claim....41

**Long-Term Disability....42**
General description of the coverage....42
When disability payments begin....42
What we will pay....43
Maternity / parental leave of absence....46
Rehabilitation program....46
Interrupted periods of disability during elimination period....47
Interrupted periods of disability after payments begin....48
If you recover damages from another person....48
Your responsibilities....48
When payments end....49
When coverage ends....49
Payments after coverage ends....49
What is not covered....49
When and how to make a claim....50

**Life Coverage....51**
General description of the coverage....51
Basic Life coverage for you....51
Optional Life coverage for you....51

Optional Life coverage for your spouse ..... 52
Who we will pay ..... 52
Suicide ..... 53
Coverage during total disability ..... 53
Early payment ..... 55
Early payment exclusion ..... 55
Converting Life coverage ..... 55
When and how to make a claim ..... 56

# General Information

## About this booklet

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

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

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

The contract holder, Sault Area Hospital, self-insures the following benefits:

- Extended Health Care
- Dental Care
- Health Spending Account

This means Sault Area Hospital has the sole legal and financial liability for the benefits listed above and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.

## Eligibility

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

- you are a permanent employee.

- you are actively working for your employer at least 37.5 hours a week.
- you have completed the waiting period.

The waiting period for your group plan ends:

- on the last day of the month in which you have completed 1 month of continuous employment for Extended Health Care and the Health Spending Account.
- on the last day of the month in which you have completed 3 months of continuous employment for Dental Care.
- after you have completed 6 months of continuous employment for Long-Term Disability.
- after you have completed 3 months of continuous employment for all other benefits.

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

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

### Who qualifies as your dependent

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

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

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

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

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

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

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

## Enrolment

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request family coverage.

You should request coverage for yourself or your dependents within 31 days of becoming eligible for coverage. If you do not request coverage during this time limit, you will be considered a late applicant and will have to provide proof of good health at your own expense and dental claims will be restricted for the first 12 months of coverage. This includes if you decline or cancel coverage for Extended Health Care and/or Dental for any reason.

If you or your dependents are covered for comparable Extended Health Care and/or Dental coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol under this plan within 31 days of loss of

other coverage. If you do not request coverage during this time limit, you will be considered a late applicant and will have to provide proof of good health at your own expense and dental claims will be restricted for the first 12 months of coverage.

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

If you requested to terminate your coverage during an approved leave of absence and you choose to re-enrol for coverage prior to the agreed upon return date or the agreed upon return date is more than 18 months after the commencement of the approved leave of absence, you will be considered a late applicant and have to provide proof of good health at your own expense and dental claims will be restricted for the first 12 months of coverage.

For Optional Life coverage, proof of good health will be required as specified in the *Life Coverage* section. Coverage will not take effect before Sun Life approves the proof of good health.

There are other cases when you will be required to provide proof of good health. Your employer will let you know when this is necessary.

**When coverage begins**

Your coverage begins on the later of the following dates:

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

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

However, if you requested to terminate your coverage during an approved leave of absence, coverage will resume on the later of the following dates:

- on the first day of the month following the month you return to work.

- the date Sun Life approves your proof of good health, if required.

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

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

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

Once you have dependent coverage, any subsequent dependents will be covered automatically. However, for claims paying purposes, you must advise your employer of the name of any subsequent dependent.

If you are not actively working on the date your spouse's Optional Life coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

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

## Changes affecting your coverage

From time to time, there may be circumstances that change your coverage. For example, your employment status may change, or your employer may change the group contract.

For Optional Employee Life coverage, changes in coverage due to age will take effect on July 1 following your birthday. If your birthday is on July 1, the change in coverage will take effect on that same day.

All other changes 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.

### 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, except as stated under *Continuation of coverage*.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

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

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

**Continuation of coverage**

When coverage would terminate because your employment ends or because you are no longer actively working, your employer is entitled to continue coverage in the following circumstances:

- during a statutory leave, as set out in applicable employment standards legislation, but not more than the period required under such legislation.
- during the notice period for termination of employment as required by relevant legislation.
- for Extended Health Care and Dental Care benefits, for a pre-

determined period during which you are temporarily laid off or on strike, but not more than 120 days.

- for Long-Term Disability benefit and Life Coverage, for a pre-determined period during which you are temporarily laid off, but not more than 3 months.

- for a pre-determined period during which you are granted a leave of absence, excluding a statutory leave or an absence due to illness, but not more than 12 months. Payment of the applicable premiums must be continued in the usual way for all benefits except Long Term Disability insurance, for which premiums are not required for the duration of your leave.

  However, if you request to terminate coverage during an approved leave of absence, coverage will continue until the last day of the month in which your leave starts.

Also, when coverage would terminate because you are no longer actively working due to illness, your employer is entitled to continue coverage under this contract during the period you are absent from work, provided that employment continues and applicable premiums are paid.

Your employer’s decision must be applied equally to all employees within the same classification.

**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 can get the proper form to make a claim on the Sun Life website at www.mysunlife.ca.

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, or electronically if indicated in the appropriate section of this booklet.

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

Limitation period for Ontario:

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

Limitation period for any other province:

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

### 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.

**Assignments**

For Life benefits, no rights or interests can be assigned.
For all other benefits, we reserve the right to refuse assignments.

**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.

***Appropriate treatment***

Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

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

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

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

***Late applicant*** For your coverage, you are a late applicant if your employer receives your enrolment more than 31 days after the later of the following dates:

- the effective date of this contract.
- the day you become eligible for coverage.
- the first day after comparable coverage ends under this or another group contract for Extended Health Care or Dental Care coverage.

For dependent coverage, you are a late applicant if your employer receives your enrolment for dependent coverage more than 31 days after you become eligible for dependent coverage.

In addition, for your coverage and dependent coverage, you are a late applicant if you requested to terminate your coverage during an approved leave of absence and you choose to re-enrol for coverage prior to the agreed upon return date or the agreed upon return date is more than 18 months after the commencement of the approved leave of absence.

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

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

# Extended Health Care
## (Medicare Supplement)

**General description of the coverage**

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. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

*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 January 1 to December 31.

**Deductible**

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

The deductible is $22.50 each benefit year for each person up to a maximum of $35 per family.

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

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

If all or part of the deductible is satisfied within the last 3 months of the benefit year, your deductible for the next benefit year will be reduced by this amount.

**Prescription drugs**

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*.

After you pay the deductible, we will cover 100% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain

maintenance drugs, in a 100 day period as ordered by a doctor.

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

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

***Drug evaluation***

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

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

***Dispensing fee***

Eligible expenses for the dispensing fee are limited to $9 for each prescription or refill.

***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.

***Prior authorization program***

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

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

You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:

- Health Canada Product Monograph.
- recognized clinical guidelines.
- comparative analysis of the drug cost and its clinical effectiveness.

- recommendations by health technology assessment organizations and provinces.
- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

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

***Reference Drug Program***

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic* category.

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.

- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending 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 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

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

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

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

In addition, we will cover the cost of room and board in a private hospital if this care has been ordered by a doctor.

The maximum amount payable is $10 per day up to a maximum of 120 days for treatment of an illness due to the same or related causes. This maximum is combined with Homewood Health Centre and The Centre for Addiction and Mental Health (CAMH).

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.

***Chronic care hospital***

We will cover 100% of the cost of room and board in a chronic care hospital.

The maximum amount payable is the difference between the cost of a ward and a semi-private room, up to a maximum of $3 per day and 120 days per person per benefit year. The deductible does not apply to these expenses.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. 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.

***Homewood Health Centre and The Centre for Addiction and Mental Health (CAMH)***

We will cover 100% of the cost of treatment received in Homewood Health Centre or The Centre for Addiction and Mental Health provided the provincial health care plan pays the equivalent of ward level accommodation.

The maximum amount payable is the difference between the cost of a ward and a private room, up to a maximum of $10 per day and 120 days for treatment of an illness due to the same or related causes. This maximum is combined with private hospital. The deductible does not apply to these expenses.

**Medical services and equipment**

We will cover 100% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
  - laboratory tests.
  - ultrasounds.
  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of $1,000 per person per benefit year.
- dental services, including braces and splints, to repair damage to

natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.

- services of an ophthalmologist or licensed optometrist, up to a maximum of $100 per person in any 24 month period.
- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye.
- wigs following chemotherapy, up to a maximum of $300 per person in a benefit year. Wigs do not require a doctor’s order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For 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.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of $200 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of $150 per brassiere and 4 brassieres per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of 5 pairs per person in a benefit year.
- elastic support stockings, including pressure gradient hose.
- custom-made orthotic inserts for shoes, when prescribed by a

doctor, podiatrist or chiropodist, up to a maximum of 2 pairs per person in a benefit year.

- custom-made orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of 1 pair and $3,000 per person in a benefit year.
- prefabricated orthopaedic shoes or modifications to prefabricated orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of 2 pairs per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $300 per person in any 36 month period. Repairs are included in this maximum.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a lifetime maximum of $700 per person.
- insulin pumps.
- medicated dressings and burn garments.
- incontinence supplies such as diapers, pads and disposable briefs required as a result of an illness.

**Paramedical services**

We will cover 100% of the costs after you pay the deductible, up to a maximum of $300 per person per specialty in a benefit year for the paramedical specialists listed below:

- licensed massage therapists.
- licensed physiotherapists.
- licensed chiropractors, including a maximum of one x-ray examination each benefit year.

We will cover 100% of the costs after you pay the deductible, for the services of licensed psychologists or social workers, up to a maximum of $35 for the first visit and a maximum of $20 per hour for each subsequent visit and a combined maximum of $200 per person in a benefit year.

We will cover 100% of the costs after you pay the deductible, for the services of licensed speech therapists, up to a maximum of $200 per person in a benefit year.

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

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 $450 per person in any 24 month period.

The deductible does not apply to eyeglasses, contact lenses or laser eye correction surgery.

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

**When coverage ends**

Extended Health Care coverage will end on the last day of the month in which the employee retires. However, you may be eligible for Extended Health Care coverage after retirement. Please contact your employer for more information.

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

**Payments after coverage ends**

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

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and

- while this provision is in force.

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

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

**What is not covered**

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, 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 the claim no later than:

- 365 days after the end of the benefit year during which you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage, whichever is earlier.

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

# Dental Care

## General description of the coverage

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 and customary charges. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the employee lives, regardless of where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

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

*Reasonable and customary charges* mean:

- charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined by Sun Life.

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

For an implant related crown or prosthesis, we will pay the benefit that would have been payable under this plan for a tooth supported crown or

a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the reasonable and customary 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 January 1 to December 31.

**Deductible**

There is no deductible for this coverage.

**Benefit year maximum**

For Major dental procedures, we will not pay more than:

- $1,000 per person for each benefit year for the construction and insertion of standard dentures.
- $1,500 per person for each benefit year for all other procedures combined.

**Lifetime maximum**

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $1,500.

**Restriction on payments for late applicants**

If you apply for coverage either for yourself or your dependents more than 31 days after becoming eligible, the maximum amount we will pay for all eligible expenses is $150 per person for the first year (12 months).

**Predetermination**

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the

dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

## Preventive dental procedures

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

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

***Oral examinations***

1 complete examination every 36 months.

1 recall examination every 9 months.

Emergency or specific examinations.

***X-rays***

1 complete series of x-rays or 1 panorex every 36 months.

1 set of bitewing x-rays every 9 months.

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

***Other services***

Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 9 months.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants.

Oral hygiene instruction once every 9 months.

## Basic dental procedures

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

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

***Fillings*** Amalgam, composite, acrylic or equivalent. Replacements must be separated by at least 12 months.

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

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

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

***Periodontics*** Treatment of disease of the gum and other supporting tissue.

For occlusal equilibration, you are covered up to a maximum of 8 units of 15 minutes per benefit year.

***Oral surgery*** Surgery, other than the removal of impacted teeth (*Preventive dental procedures*). The following temporomandibular joint dislocation management procedures are also covered:

- dislocation, open reduction.
- dislocation, closed reduction.
- luxation.

***Anaesthesia*** Anaesthesia in conjunction with a dental procedure covered under this plan, other than the removal of impacted teeth (*Preventive dental procedures*)

***Repair*** Repair of bridges or dentures.

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

## Major dental procedures

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

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

***Major restorations*** Crowns and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*). Replacements must be separated by at least 5 years.

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

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

## 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.

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

The following orthodontic procedures are covered:

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

## When coverage ends

Dental Care coverage will end on the last day of the month in which the

employee retires. However, you may be eligible for Dental Care coverage after retirement. Please contact your employer for more information.

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

**Payments after coverage ends**

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

If the Dental Care benefit terminates for reasons other than the termination of this plan or termination of the Dental Care benefit under this plan, you may continue to be eligible for expenses incurred for endodontic treatment that exposes a tooth or procedures related to dentures, crowns or bridges. The treatment or procedure must be a work in progress which commenced while you were covered under this plan and the expense must be incurred within 31 days after the end of your Dental Care coverage.

**What is not covered**

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.

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

We will also not pay for dental work resulting from:

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

**When and how to make a claim**

To make a claim, complete the claim form that is available from your employer. The dentist will have to complete a section of the form.

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

- 365 days after the end of the benefit year during which you incur the expenses, or
- 90 days after the end of your Dental Care coverage, whichever is earlier.

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.

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

# 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 April 1, 2024 to December 31, 2024 and then from January 1 to December 31

**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.
" 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

**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.

| | |
|---|---|
| ***Licensed practitioners (fee for services)*** | ■ 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), therapeutists. |
| ***Dental care*** | ■ preventative, diagnostic, restorative, orthodontic and therapeutic care. |
| ***Attendant care*** | ■ 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. |
| ***Facilities*** | ■ 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. |
| ***Hospitals*** | ■ payments to a public or licensed private hospital. |
| ***Devices and supplies*** | ■ 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.

**When coverage ends**

Health Spending Account coverage will end on the last day of the month in which the employee retires. Coverage may also end on an earlier date, as specified in *General Information*.

**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 or on our website at www.mysunlife.ca.

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.

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

# Long-Term Disability

**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 following appropriate treatment for the disability since its onset.

For your Long-Term Disability coverage,

- during the first 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 the essential duties of your own 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 of 30 weeks or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

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

If you become totally disabled during a lay-off 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 an uninterrupted period of 30 weeks and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

If you are unable to return to work due to Total Disability, you will be considered disabled as of your scheduled return date. The Long-Term Disability elimination period will begin as of the date you are scheduled to return to active work.

**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: The payment calculation is determined based on your years of continuous service with the employer, as described below:

- if you have at least 6 months, but less than 20 years of continuous service – 65% of your monthly basic earnings.
- if you have at least 20 years, but less than 30 years of continuous service – 70% of your monthly basic earnings.
- if you have at least 30 years of continuous service – 75% of your monthly basic earnings.

The maximum benefit amount is $50,000.

Step 2: We subtract any income provided to you:

- in connection with the same or a subsequent disability under any government-sponsored plan*, excluding dependent benefits and employment insurance benefits.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a

deduction.

- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.**
- under the Québec Parental Insurance Plan.

The result from Step 2 is the amount you will normally receive.

If this amount plus the above sources of income and all the additional sources of income listed below exceeds 100% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 80% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

- under any Workers' Compensation Act or similar law for another disability.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.

*If you first become entitled to Québec Pension Plan (QPP) disability benefits:

- before age 60, we will deduct the amount provided in your Notice of Entitlement (NOE) for the duration of your claim.
- on or after age 60, we will deduct the amount provided in your NOE and an additional amount. The additional amount represents a portion of the retirement amount, payable or available following an approved QPP disability application, and is comparable to the variable portion of QPP disability benefits for persons under age 60. These deducted amounts will not change for the duration of your disability claim.

**If you choose to apply for**,** and are approved for**,** the HOOPP disability pension benefit, you will receive a disability pension benefit (immediate, unreduced pension based on your contributory service)

upon termination of your employment with the hospital. If you choose to take free accrual (you continue to build contributory service under the plan while off work due to disability) there will be no change to your monthly Long Term Disability payments. If you decide to take the disability pension benefit, we will subtract the amount of disability pension you are receiving from your monthly Long Term Disability payments.

If you are entitled to any of the amounts described above, other than the HOOPP Disability pension benefit, we will estimate the amount of such benefits or income and deduct the estimated amount from your monthly disability benefit when you:

- fail to apply for the benefits or income, or exhaust all levels of appeal.
- fail to make a new application, following a declined application or appeal.
- refuse to receive or accept some or all of the benefits or income, or choose to cancel them.
- fail to provide us with information related to:
  - the status of an application, appeal or reapplication,
  - the benefit or income amount, even if it has been refused or cancelled,

  within 30 days of our request for information.

If you choose not to apply for the HOOPP Disability pension benefit, you will not be penalized and no estimated offset will be applied to 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. However, increases in those benefits as a result of

your disability will be taken into account.

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

The amount of monthly disability benefit before age 65, and after reductions, will not be less than $50 per month.

**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 of 30 weeks, 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, the Long-Term Disability payments will be reduced by 50% of the income you receive under the rehabilitation program. If during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), 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.

**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 there is no interruption of more than 3 weeks.

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.

**If you recover damages from another person**

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused your disability.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

We have the right to withhold or discontinue disability income payments if you refuse or fail to comply with any of these terms.

**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.
- return to your own occupation during the first 24 months of total disability.
- 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 of total disability.
- try to obtain work in another occupation after the first 24 months of total disability.

- obtain benefits or income that may be available from other sources.

If you do not, Sun Life may reduce, 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.
- if you have completed less than 10 years of continuous service with the employer when you become totally disabled – the day you reach age 65, or until the end of a maximum benefit period of 12 months if you have not already received 12 months of Long-Term Disability payments when you reach age 65.
- the date you die.

**When coverage ends**

Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 30 weeks 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 benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

**What is not covered**

We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved 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 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:

- 60 days 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

## General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your spouse's Life coverage provides a benefit if your spouse dies while covered.

## Basic Life coverage for you

### *Amount*

Your Life benefit is:

- Option 1 – $5,000.
- Option 2 – 2 times your annual basic earnings, rounded to the nearest $500. The maximum amount of coverage is $3,000,000.

### *Proof of good health*

Proof of good health is required if you wish to increase your coverage. Coverage will not take effect before Sun Life approves the proof of good health.

### *Coverage ends*

Your coverage will end when you retire or reach age 65, whichever is earlier. However, you may be eligible for Basic Life coverage after retirement. Please contact your employer for more information.

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

## Optional Life coverage for you

### *Amount*

You can choose Optional Life coverage for you. Your choices are based on your age, as described below:

- if you are under age 55 – 1, 2 or 3 times your annual basic earnings. The result is rounded to the nearest $500.
- if you are age 55 or over, but under age 60 – 1 or 2 times your annual basic earnings. The result is rounded to the nearest $500.
- if you are age 60 or over – 1 times your annual basic earnings.

The result is rounded to the nearest $500.

***Overall maximum*** The maximum amount of coverage for your basic and optional benefits combined is $3,000,000.

***Proof of good health*** Proof of good health will be required when you request optional coverage and any increase in that coverage, except for the first $150,000 if the request is made within 31 days of eligibility.

***Coverage ends*** Your coverage will end when you retire or reach age 65, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

## Optional Life coverage for your spouse

***Amount*** You can choose Optional Life coverage for your spouse. The amount is based on a percentage of your Optional Life amount and is determined as follows:

- Option 1 – 25% of your Optional Life coverage amount.
- Option 2 – 50% of your Optional Life coverage amount.

***Proof of good health*** Proof of good health for your spouse will be required when you request optional coverage for your spouse and any increase in that coverage.

***Coverage ends*** Optional coverage for your spouse will end when you retire or reach age 65, or when your spouse reaches age 65, 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.

For your spouse's optional coverage, Sun Life will pay the full amount

of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

Your beneficiary designation filed under a previous group plan of the employer, will apply and carry forward to your coverage under this plan until you change it. Please review your existing beneficiary designation to ensure it reflects your current intentions.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and desire to designate a minor as your beneficiary, you may wish to designate someone else to receive the death benefit in trust for the minor. If a trustee is not designated, applicable legislation may require that a death benefit payable to a minor be paid instead to a court, or guardian or public trustee. If you reside in Québec and have designated a minor as beneficiary, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively (and regardless of whether you reside outside or in Québec), you may wish to consider designating your estate (or your spouse's estate in the case of Optional Life coverage for your spouse) as beneficiary and provide the executor(s) with directions in your (or your spouse's) will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

**Suicide**

If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions. However, we will refund all applicable Life coverage premiums that have been paid.

**Coverage during total disability**

**For Basic Life coverage:**

If you become totally disabled before you retire or reach age 65, whichever is earlier, Basic 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 notice of your total disability within 12 months of the date the disability begins. Proof of your total disability must be

received within 90 days of the date we receive your notice of total disability. After that, we can require ongoing proof that you are still totally disabled.

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

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

This coverage will continue without payment of premiums, from the date the above period ends, 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 Basic 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.

**For Optional Life coverage:**

If you become totally disabled before you retire or reach age 65, whichever is earlier, your Optional Life coverage will continue without the payment of premiums while you are receiving Long-Term Disability benefit payments. 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.

If you start receiving Long-Term Disability benefit payments 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.

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

**Early payment**

Subject to Sun Life's approval, you may elect early payment of the death benefit equal to 90% of the amount of Basic Life Insurance applicable to you, subject to the following conditions:

- a doctor appointed by Sun Life determines that you are apparently certain to die within 12 months of the date of such determination;
- you are competent to act;
- you are under age 64 at the time you make the election.

The Early payment is in exchange for all other benefits under the Employee Basic Life Insurance provisions.

*Value of the Early payment* means the aggregate of the payments made under the Early payment, plus the reasonable costs of verifying your medical condition.

**Early payment exclusion**

The Early payment will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Early payment is paid, the Value of the Early payment will be repaid to Sun Life by the recipient of the Early payment.

**Converting Life coverage**

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

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

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

Life coverage.

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

**When and how to make a claim**

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

## Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

## 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).