Sun Life Financial

your group benefits

NAV CANADA Bargaining Agents Association Trust Fund

Eligible represented retirees of NAV CANADA who retire on or after January 1, 2010

Contract Number 150052
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Table of Contents

General Information 1
About this booklet 1
Eligibility 1
Who qualifies as your dependent 2
Proof of eligibility 3
When coverage begins 3
Updating your records 3
When coverage ends 4
Making claims 4
Legal actions 5
Coordination of benefits 5
Recovering overpayments 6
Definitions 7

Hospital 8
Eligible expenses 8
Hospital Benefit 8
Proof of claim 8
Payment of benefit 8
Calendar year maximum 9
Limitations 9
Exclusions 9

Extended Health Care 11
Eligible expenses 11
Calendar year maximum 11
Type 1 – Prescription Drug Benefit 12
Type 2 – Additional Health Care Benefit 18
Type 3 – Paramedical and Vision Care Benefit 24
Type 4 – Dental Care Benefit 25
Proof of claim 28
Payment of benefit 28
Prescription drug deductible 28
Limitations 29
Exclusions 29
Integration with government programs 30

Emergency Travel Assistance 32

Dental Insurance 38
Suggested Fee Guide..38
Maximum Benefit 39
Eligible Expenses..39
Pre-Determination..46
Alternate Procedures 46
Limitations 47
Exclusions 47
Making a Claim..48

General Information

About this booklet

The information in this group benefits booklet is important to you. It provides the information you need about your group benefits plan.

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 group benefits booklet, or you need additional information about your group benefits, please contact the contract holder.

The contract holder, NAV CANADA Bargaining Agents Association Trust Fund, self-insures all benefits. This means that NAV CANADA Bargaining Agents Association Trust Fund plays a role similar to that of an insurance company for its employees. NAV CANADA Bargaining Agents Association Trust Fund has the sole legal and financial liability for all benefits and funds the claims from its net income, retained earnings or other financial resources. Sun Life provides administrative services only (ASO) such as claims processing.

Eligibility

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

- you must be covered under a provincial medicare plan or federal government plan that provides similar benefits.
- you retire on or after January 1, 2010.
- you were covered as an union employee under the NAV CANADA group plan on the day preceding your retirement.
- when you retire, you do not opt for a transfer of the commuted value of your pension entitlement and you are eligible for an immediate pension benefit.

- you have at least 15 years of pension eligibility service and be in receipt of a monthly pension from NAV CANADA.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada. To qualify for coverage, your dependent must be covered under a provincial medicare plan or federal government plan that provides similar benefits.

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.

A legally separated spouse continues to qualify as an eligible dependent until the date the marriage is dissolved through divorce or annulment.

You can only cover one spouse at a time.

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

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 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. The contract holder can give you more information about this.

Proof of eligibility

Supporting documents as defined below must be provided to and approved by the contract holder before coverage is in effect.

Spouse – Both the birth certificate of spouse and marriage certificate.

Common law spouse – Both the birth certificate of common law partner and statutory declaration.

Child – Birth certificate.

Foster child – Birth certificate and legal guardianship documentation.

Adopted child – Birth certificate (and legal guardianship documentation if not on birth certificate).

Step-child – Birth certificate (will only be eligible if spouse/common-law partner approved).

Child over age 21 – Proof of enrolment as full-time student (to be provided annually) OR approval of disability status from Sun Life (to be provided once).

When coverage begins

Your coverage will begin on the date you become eligible for coverage.

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

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

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

Updating your records

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

- change of dependents.

- change of name.

When coverage ends

Your coverage will end on the date the benefit provision under which you are covered terminates.

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

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.

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

- the date the person would no longer be considered your dependent if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim.

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

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

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

Legal actions

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

Coordination of benefits

If you or your dependents are covered for Hospital, 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.

The contract holder can help you determine which plan you should claim from first.

Recovering overpayments

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

Definitions

Here is a list of definitions of some terms that appear in this group 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.

Benefit year ***Extended Health Care***: January 1 to December 31.

Dental Insurance: October 1, 2023 to December 31, 2023, and then from January 1 to December 31.

Dentist A person licensed to practise dentistry, and who is operating within the scope of his licence.

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

Hospital An institution designated as such by law for the care and treatment of sick and injured persons which has organized facilities for diagnostic treatment and major surgery and which provides 24 hour nursing services, including beds set aside in such an institution for convalescent care and also including any legally licensed hospital providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis or chronically ill persons. This does not include a nursing home, rest home, home for custodial care of the aged or chronically ill, a sanatorium or a convalescent hospital.

Illness An illness is a bodily injury, disease, mental infirmity or sickness.

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

Hospital

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

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

Eligible expenses

Eligible expenses are charges for the following services or supplies which are medically necessary and customarily provided in relation to the nature and severity of the illness and which do not exceed the general level of charges in the area where the expense is incurred as determined by Sun Life.

Hospital Benefit

Covered percentage – 100%

Charges for room and board in a hospital up to the hospital's semi-private rate excluding hospital charges referred to as coinsurance charges or user fees (including, where permitted by law, any admittance charges).

Proof of claim

Proof of claim must be received by Sun Life not later than 3 months after the end of the benefit year during which the expenses were incurred, unless, in Sun Life's opinion, it was not reasonably possible to submit the claim within this period. In such case, proof of claim must be received by Sun Life as soon as reasonably possible, but not later than 18 months after the end of the benefit year during which the expenses were incurred.

Payment of benefit

Upon receipt of proof of claim that a person while covered incurred an eligible expense, a benefit is paid subject to Limitations, Exclusions and Coordination of benefits.

Each eligible expense is allocated to the benefit year in which it is deemed incurred.

An eligible expense is deemed to be incurred on the date the service is

received or on the date supplies are purchased or rented.

Each eligible expense is multiplied by the covered percentage to determine the amount payable, once the eligible expense maximum is applied.

Calendar year maximum

All hospital and extended health care claims incurred in Canada will be subject to a calendar year combined maximum of $100,000 per eligible claimant.

Limitations

Payment is not made for

1. 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.
2. any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.
3. services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
4. services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.
5. services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

Exclusions

A benefit is not paid for

1. charges incurred for an illness due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.
2. charges for services and supplies, rendered or prescribed by a person who is normally resident in the patient's home or who is related to the patient by blood or marriage.
3. charges for services or supplies for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of an accident.
4. any service or supply for which there would be no charge in the

absence of this coverage.

5. charges for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes.
6. charges for experimental services or supplies, for which substantial evidence provided through objective clinical testing of the service's or supply's safety and effectiveness for the purpose and under the conditions of the recommended use does not exist to Sun Life's satisfaction.
7. the portion of any charge which is the legal liability of another party.
8. charges for services provided by a doctor licensed and practising in Canada where the person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included under this provision.
9. expenses for benefits which are legally prohibited by the government from coverage.
10. the portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program.
11. the portion of charges for services or supplies provided in a hospital outside of Canada that would normally be payable under a provincial health or hospital plan if the service or supply had been rendered in a hospital.

Extended Health Care

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

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

Eligible expenses

Eligible expenses are charges for the following services or supplies which are medically necessary and customarily provided in relation to the nature and severity of the illness and which do not exceed the general level of charges in the area where the expense is incurred as determined by Sun Life. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Calendar year maximum

All hospital and extended health care claims incurred in Canada will be subject to a calendar year combined maximum of $100,000 per eligible claimant.

Type 1 – Prescription Drug Benefit

Covered percentage

– for items 11 and 12: 100% in excess of the deductible

– for all other items: 80% in excess of the deductible.

For employees residing in Québec, the reimbursement percentage is increased to 100% for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached. However, if the drug submitted for reimbursement has a lower priced equivalent drug, only the cost of the lowest priced equivalent drug will be considered at 100%, unless Sun Life specifically approved the cost of the higher priced drug.

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

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

Charges for

1. drugs which legally require a prescription.
2. intrauterine devices (IUDs) and diaphragms.
3. life-sustaining drugs which may not legally require a prescription.
4. replacement therapeutic nutrients prescribed by an accredited medical specialist for the treatment of an illness excluding allergies or aesthetic ailments, provided that there is no other nutritional alternative to support the life of the person.
5. injectable drugs, including allergy serums administered by injection.
6. compounded prescriptions, regardless of their active ingredients.
7. diabetic supplies (except needles and syringes are not eligible for the 36 month period following the date of purchase of an insulin jet injector device).
8. vitamins and minerals which are prescribed for the treatment of a chronic disease, when in accordance with customary practice of

medicine, the use of such products are proven to have therapeutic value and no other alternatives are available to the person.

9. drug delivery devices to deliver asthma medication, which are integral to the product, and approved by Sun Life.
10. aerochambers with masks for the delivery of asthma medication for children under age 6.
11. smoking cessation products which legally require a prescription. The maximum amount payable during each person's lifetime is $1,000.
12. drugs for the treatment of sexual dysfunction. The maximum amount payable is $1,300 per person in a benefit year.
13. drugs used for the treatment of obesity, including injectable vitamins and dietary supplements, prescribed by a doctor when used in conjunction with a weight loss drug program, subject to prior approval.

Ineligible Expenses

Payment is not made for

1. drugs which in Sun Life's opinion, are experimental.
2. publicly advertised items or products which, in Sun Life's opinion, are household remedies.
3. vitamins, minerals and protein supplements, other than those indicated as eligible expenses.
4. therapeutic nutrients other than those indicated as eligible expenses.
5. any charge for diets and dietary supplements, other than those indicated as eligible expenses.
6. infant foods and sugar or salt substitutes.
7. lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives or emollients.
8. surgical supplies and diagnostic aids.
9. drugs which are used for cosmetic purposes.
10. drugs which are used for a condition or conditions not

recommended by the manufacturer of the drugs.

11. expenses incurred under any of the conditions listed under Limitations and Exclusions.
12. natural health products, whether or not they have a Natural Product Number (NPN).
13. 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.

The payment for a single purchase of a Type 1 eligible expense is limited to the cost of a supply which could reasonably be consumed or used within 100 days from the date of purchase.

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.

Smoking cessation products

For employees residing in Québec, smoking cessation products are covered in accordance with the requirements under the Québec drug insurance plan.

Pharmaceutical services (rendered by pharmacists)

We will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.

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.

For employees residing in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, charges in excess of the lowest priced equivalent drug do not count towards the out-of-pocket maximum unless Sun Life specifically approved the charges for the higher priced drug.

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.

Québec drug insurance plan

Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements.

Out-of-pocket maximum

For employees residing in Québec, expenses incurred for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary and not reimbursed under this plan as a result of the application of the deductible or the reimbursement level are limited in each calendar year to the yearly maximum contribution set by the RAMQ plan. There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the employee.

Persons age 65 or over

Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the RAMQ's public prescription drug insurance plan, which provides basic coverage for prescription drugs costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be insured by either the public plan or your group plan.

If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium.

On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact your benefits administrator to clarify your situation. Unfortunately, we cannot change your file without confirmation from your benefits administrator.

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.

Type 2 – Additional Health Care Benefit

Covered percentage

– for items 3, 4, 5, 13, 14, 15, 16 and 20 – 100%

– for all other items – 80%

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

Additional Health Care, other than wigs, must be ordered by a doctor.

Charges for

1. use of a licensed ambulance for local transportation of the person to the nearest hospital qualified to render the necessary medical services.
2. use of a licensed air ambulance for transportation of the person to the nearest hospital qualified to render necessary emergency medical services.

3. the following services outside the person's province of residence for emergency services or referrals provided the charges are in excess of the amount payable by a provincial health insurance plan

   A. room and board in a hospital up to the hospital's ward rate (including where permitted by law, any admittance, coinsurance, or utilization charges).

   B. other hospital services (provided out of Canada).

   C. out-patient services in a hospital.

   D. services of a doctor.

   Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives. Coverage for emergency services is subject to all conditions indicated in this benefit provision under *Out-of-province emergency services* and *Emergency services excluded from coverage*.

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

   Eligible expenses for emergency services must be incurred within 60 days of the date the person leaves his province of residence. If hospital admittance takes place within such period, in-patient services are covered until the date of discharge.

   A referral must be for treatment of an illness and made in writing by a doctor located in the person's province of residence. Services rendered in such cases:

   A. must be rendered in Canada if such services (irrespective of any waiting lists) are available in Canada, or may be rendered out of Canada if such services are not available in Canada, and

   B. must be services for which the provincial Medicare Plan of

the person's province of residence agrees, in writing, to pay benefits to such person as a result of the referral.

For emergency services: The maximum amount payable per period of travel is $1,000,000 for each person.

For referred services: The maximum amount payable per illness is $25,000 for each person.

4. services, while not confined in a hospital, of a private duty nurse. The maximum amount payable in any benefit year is $15,000 for each person. (A *private duty nurse* is a registered nurse, or nursing assistant, licensed, registered or certified through the respective provincial licensing body or professional organization as the case may be. In the absence of such a registry, this will include a nurse with comparable qualifications as determined by Sun Life.)

5. wigs following total hair loss as the result of an illness. The maximum amount payable during each person's lifetime is $500.

6. rental, or purchase at Sun Life's option, of durable equipment manufactured specially for medical use and which is required for temporary and therapeutic use in the person's private residence. Eligible equipment must be approved by Sun Life and includes, but is not limited to, items such as

   A. walkers.

   B. hospital beds.

   C. apnea monitors.

   D. alarm systems for enuretic persons.

   Payment will be limited to the cost of non-motorized equipment unless medically proven that the person requires motorized equipment.

7. rental, or purchase at Sun Life's option, of a wheelchair, required for therapeutic use in the person's home. Payment will be limited to the cost of non-motorized equipment unless medically proven that the person requires motorized equipment. Repairs and replacement of a purchased wheelchair are eligible expense, but not within 60 months of the last purchase of a wheelchair.

8. casts, splints, trusses, crutches, cervical collars and braces which

contain either metal or hard plastic, excluding dental braces and braces used primarily for athletic use.

9. mammary prostheses following surgery, and their replacements. Replacements are limited to 1 replacement for each prostheses in any period of 24 consecutive months.
10. temporary artificial limbs.
11. artificial eyes and permanent artificial limbs to replace temporary artificial limbs, and their replacements, but not within
    A. 60 months of the last purchase in the case of a retiree or a dependent over 21 years of age, or
    B. 12 months of the last purchase in the case of a dependent 21 years of age or less

    unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.
12. elasticized support stockings and elasticized apparel for burn victims, manufactured to the person's specifications or having a minimum compression of 30 millimetres.
13. orthopaedic brassieres. The maximum amount payable in any benefit year is $100 for each person.
14. orthotic inserts for shoes. The maximum amount payable in any benefit year is $300 for each person.
15. orthopaedic shoes which are an integral part of a brace or custom made orthopaedic shoes, including modifications to such shoes, prescribed in writing by a doctor or a podiatrist. The maximum amount payable for each person in any benefit year is the lesser of (i) $150, and (ii) the total charge, less the average cost of regular footwear as determined by Sun Life.
16. hearing aids, other than those in item 21, prescribed in writing by an otolaryngologist, and their repairs. The maximum amount payable in any period of 60 consecutive months is $500 for each person.
17. oxygen and its administration.
18. glucometers, and their repair and replacement, for insulin dependent diabetics and for non-insulin dependent diabetics who are legally blind or colour blind. Repairs and replacements are

not permitted within the 60 month period following the date of purchase.

19. insulin pumps and associated equipment, and their repair and replacement, for insulin dependent diabetics when prescribed by a doctor who is associated with a recognized centre for the treatment of diabetics at a university teaching center in Canada. Repairs and replacements are not permitted within the 60 month period following the date of purchase.
20. insulin injector devices for insulin dependent diabetics. The maximum amount payable in any period of 36 consecutive months is $760 for each person.
21. the initial purchase of eyeglasses, contact lenses or hearing aids when required as the direct result of surgery or an accident provided the purchase is made within 6 months after the date of the surgery or accident. This time limit may be extended if, in Sun Life's opinion, the purchase could not have been made within this time frame.
22. colostomy, ileostomy and tracheostomy supplies, and catheters and drainage bags for incontinent, paraplegic or quadriplegic persons.
23. doctor's services where such services are not eligible for reimbursement under the person's provincial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial health insurance plans.

    Where only one province provides reimbursement for a particular service, and that province discontinues the coverage, the issue will be subject to review by the Board of Trustees as to whether coverage will also be discontinued under this Plan.

    Claims for such services, following cessation of provincial coverage, will be held by Sun Life pending the decision of the Board of Trustees.

    Where a province begins reimbursement for a particular service, claims for the service will be held by Sun Life pending a review by the Board of Trustees as to whether the service should be covered under this Plan in the other province and territories.

24. bandages and surgical dressings required for the treatment of an open wound or ulcer.
25. laboratory tests done in a commercial laboratory for diagnosis of an illness (but excluding any tests performed in a doctor's office or a pharmacy).
26. Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, up to a combined maximum of $4,000 per person per benefit year. You must provide us with a doctor's note confirming the diagnosis.

Out-of-province emergency services

Eligible expenses for emergency services outside the person's province of residence are subject to all the conditions indicated below.

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

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

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

Emergency services excluded from coverage

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

1. services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.

2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Sun Life's ETA provider, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
4. services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
5. where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Type 3 – Paramedical and Vision Care Benefit

Covered percentage

– for items 1A, 1B, 1C, 1E and 3 – 100%

– for all other items – 80%

Charges for

1. the following paramedical services (including utilization charges where permitted by law)
   A. services of practitioners licensed as speech therapists or chiropractors and services of a doctor for similar treatment, including x-ray examinations ordered by a chiropractor or a doctor. All practitioners must be licensed, registered or certified through the respective provincial licensing body or professional organization as the case may be. Services of a speech therapist must be ordered by a doctor. The maximum amount payable in any benefit year is $500 per discipline, for each person.
   B. services of a licensed psychologist when ordered by a doctor. The maximum amount payable in any benefit year is $1,000 for each person.

C. services of practitioners licensed as osteopaths (this category of paramedical specialists also includes osteopathic practitioners), acupuncturists, podiatrists/chiropodists, naturopaths or massage therapists, including x-ray examinations ordered by each licensed practitioner. All practitioners must be licensed, registered or certified through the respective provincial licensing body or professional organization as the case may be. The maximum amount payable in any benefit year is $300 per discipline, for each person.

D. services of a licensed physiotherapist when ordered by a doctor.

E. services of a doctor or a licensed electrologist for removal of excessive hair from exposed areas of the face and neck when the person suffers from severe emotional trauma as a result of this condition. Such services must be ordered by a psychiatrist or a psychologist. The maximum amount payable for each person is $20 per visit.

2. eye examinations performed by a licensed optometrist. The maximum amount payable every 2 calendar years, with the first 2 year period commencing on January 1, 2010 and ending on December 31, 2011, is for one eye examination for each person.

3. contact lenses or lenses and frames for eyeglasses, and their repairs, or laser eye correction surgery. Supplies must be prescribed in writing by an ophthalmologist or a licensed optometrist and must be dispensed by an ophthalmologist, a licensed optometrist or a qualified optician. Laser eye correction surgery must be performed by an ophthalmologist. The maximum payable every 2 calendar years, with the first 2 year period commencing on January 1, 2010 and ending on December 31, 2011, is $200 for each person. For laser eye surgery only, the maximum payable of $200 can be claimed in every 2 year block until the total cost of the surgery has been reimbursed, provided the claimant remains covered under the Plan.

Type 4 – Dental Care Benefit

Covered percentage – 80%

Charges for

1. dental services, including braces and splints to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while a person is covered. These services must be received within 12 months of the accident. Sun Life will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the retiree lives. The guide must be the current guide at the time that treatment is received.
2. the following oral surgical procedures performed by a Dentist up to amount specified for the procedure in the provincial Dental Association Fee Guide for a general practitioner which is current on the date of treatment (i) in the province where the service is rendered, if the service is rendered in Canada, (ii) in the province where the person resides, if the person is a resident of Canada and the service is rendered outside of Canada, and (iii) in Ontario, if the person is not a resident of Canada and the service is rendered outside of Canada.

   A. cysts, lesions, abscesses
      - (a) biopsy
         - (i) soft tissue lesion
         - (ii) incision
         - (iii) excision
         - (iv) hard tissue lesion
      - (b) excision of cysts
      - (c) excision of benign lesion
      - (d) excision of ranula
      - (e) incision and drainage
         - (i) intra oral - soft tissue
         - (ii) intra osseous - (into bone)
      - (f) periodontal abscess - incision and drainage

   B. gingival and alveolar procedures
      - (a) alveoplasty

- (b) flap approach with curettage
- (c) flap approach with osteoplasty
- (d) flap approach with curettage and osteoplasty
- (e) gingival curettage
- (f) gingivectomy with or without curettage
- (g) gingivoplasty

C. removal of teeth or roots

- (a) removal of impacted teeth
- (b) removal of root or foreign body from max. antrum
- (c) root resection - (apiectomy or apicoectomy)
  - (i) anterior teeth
  - (ii) bicuspids
  - (iii) molars

D. fractures and dislocations

- (a) dislocation - temporo-mandibular joint (or jaw)
  - (i) closed reduction
  - (ii) open reduction
- (b) fractures - mandible
  - (i) no reduction
  - (ii) closed reduction
  - (iii) open reduction
- (c) fractures - maxillar or malar
  - (i) no reduction
  - (ii) closed reduction
  - (iii) open reduction
  - (iv) open reduction (complicated)

E. other procedures

- (a) avulsion of nerve - supra or infra-orbital
- (b) frenectomy - labial or buccal (lip or cheek)
- (c) lingual (tongue)

(d) repair of antrooral fistula
(e) sialolithotomy - simple
(f) sialolithotomy - complicated
(g) sulcus deepening, ridge reconstruction
(h) treatment of traumatic injuries
    (i) repair of soft tissue lacerations
    (ii) debridement, repair, suturing
(i) torus – (bone biopsy)

Proof of claim

Proof of claim must be received by Sun Life not later than 3 months after the end of the benefit year during which the expenses were incurred, unless, in Sun Life's opinion, it was not reasonably possible to submit the claim within this period. In such case, proof of claim must be received by Sun Life as soon as reasonably possible, but not later than 18 months after the end of the benefit year during which the expenses were incurred.

Payment of benefit

Upon receipt of proof of claim that a person while covered incurred an eligible expense, a benefit is paid subject to Limitations, Exclusions and Coordination of benefits.

Each eligible expense is allocated to the benefit year in which it is deemed incurred.

An eligible expense is deemed to be incurred on the date the service is received or on the date supplies are purchased or rented.

The eligible expense is multiplied by the covered percentage to determine the amount payable.

The deductible, if any, is applied against the eligible expense and the result multiplied by the covered percentage to determine the amount payable.

Prescription drug deductible

$4 for each prescription or refill.

Limitations

Payment is not made for

1. 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*.
2. any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.
3. services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
4. services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.
5. services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

Exclusions

A benefit is not paid for

1. charges incurred for an illness due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.
2. charges for services and supplies, rendered or prescribed by a person who is normally resident in the patient's home or who is related to the patient by blood or marriage.
3. charges for services or supplies for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of an accident.
4. any service or supply for which there would be no charge in the absence of this coverage.
5. charges for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes.
6. charges for experimental services or supplies, for which substantial evidence provided through objective clinical testing of the service's or supply's safety and effectiveness for the purpose and under the conditions of the recommended use does

not exist to Sun Life's satisfaction.

7. the portion of any charge which is the legal liability of another party.
8. charges for services provided by a doctor licensed and practising in Canada where the person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included under this provision.
9. expenses for benefits which are legally prohibited by the government from coverage.
10. the portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program.
11. the portion of charges for services or supplies, other than those listed in Type 2 items 3 and 4, provided in a hospital outside of Canada that would normally be payable under a provincial health or hospital plan if the service or supply had been rendered in a hospital in Canada.
12. charges for items purchased primarily for athletic use.
13. dental expenses, other than those indicated as eligible expenses.
14. expenses for ambulance services for a medical evacuation which are eligible under the Emergency Travel Assistance Benefit Provision.
15. expenses for repairs or replacement of purchased durable equipment.
16. coinsurance charges or similar charges for hospital care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan and which are not charges made for utilization of semi-private or private accommodation.

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.

Emergency Travel Assistance

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

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

General description of the coverage

If you are faced with a medical emergency when travelling outside of the province where you live, Sun Life's Emergency Travel Assistance (ETA) provider can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Sun Life's ETA provider. If contact with Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider must be made as soon as possible afterwards. If contact is not made and emergency services are

provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Sun Life's ETA provider may arrange for:

On the spot medical assistance

Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities.

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

Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel.

Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Sun Life's ETA provider may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation.

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live:

1. for you, if due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated; or

2. for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified attendant to accompany them home. The attendant is subject to the approval of you or a member of your family.

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

Travel expenses of family members

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

1. you are travelling alone, or

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

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

Repatriation

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

Vehicle return

Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 for the return of a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from returning the vehicle.

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Sun Life's ETA provider will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

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

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

The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the

other plans the expenses that exceed its share.

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Sun Life's ETA provider:

1. any amounts which are or will be reimbursed to you by your provincial medicare plan.

2. that portion of any amount which exceeds the maximum amount of your coverage under this plan.

3. amounts paid for services or supplies not covered by this plan.

4. amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

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

Limits on Emergency Travel Assistance coverage

There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before your departure.

Sun Life's ETA provider reserves the right to suspend, curtail or limit

its services in any area, without prior notice, because of:

1. a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.

2. the refusal of authorities in the country to permit Sun Life's ETA provider to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Sun Life's ETA provider

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

Dental Insurance

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.

If, while insured, you or your Dependents incur any of the Eligible Expenses listed below, Sun Life will pay a benefit, subject to Limitations and Exclusions. After the application of the deductible, if any, for each benefit Year, the amount payable is determined by using the Insured Percentages shown for the types of procedures, and based on the lower of (i) the actual charge and (ii) the amount in the Suggested Fee Guide. A benefit is not payable for an Eligible Expense used to satisfy the deductible nor after the Maximum Benefit has been paid.

Suggested Fee Guide

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.

If dental services or supplies are provided by a board qualified specialist in endodontia, prosthodontia, oral surgery, periodontal surgery, paedodontia or orthodontics who limits his practice only to treatment within his area of specialization, then, the fee guide indicated below for the specialist approved by the relevant Dental Association.

For services rendered in Canada for a person who is a resident of Canada.

The fee guide which is current on the date of treatment for dental services or supplies approved by the Provincial Dental Association where treatment is rendered. If the average increase of the provincial fee guides exceeds 3.25% for any given year, the revised fee guide under this Plan is subject to pre-approval by the Plan Sponsor.

For services rendered outside of Canada for a person who is a resident of Canada.

The fee guide which is current on the date of treatment for dental services or supplies approved by the Provincial Dental Association in the person's Province of residence. If the average increase of the provincial fee guides exceeds 3.25% for any given year, the revised fee guide under this Plan is subject to pre-approval by the Plan Sponsor.

For a person who is not a resident of Canada.

The fee guide which is current on the date of treatment for dental services or supplies approved by the Ontario Dental Association. If the average increase of the provincial fee guides exceeds 3.25% for any given year, the revised fee guide under this Plan is subject to pre-approval by the Plan Sponsor.

Maximum Benefit

The Maximum Benefit payable, other than Module E, for each covered person is $1,750 each benefit Year. If a person's coverage commences in the second half of a benefit Year, the Maximum Benefit payable for such person in that benefit Year will be reduced by $875.

The Module E Maximum Benefit payable for each covered person during his lifetime is $2,500.

Eligible Expenses

MODULE A - PREVENTIVE, DIAGNOSTIC, EMERGENCY OR PALLIATIVE SERVICES

Covered Percentage – 90% without a deductible

Charges for

1. oral examination
   - A. complete examinations.
   - B. recall examinations – limited to one during any 9 month period.
   - C. emergency examinations and/or consultations.
   - D. specific examinations.

2. consultations
   - A. treatment planning.
   - B. with patient.
   - C. with another Dentist.

3. specific diagnostic procedures

A. biopsy, soft-hard tissues.

B. pulp vitality tests.

4. radiographs and radiographic interpretations

A. intraoral periapical films, when required to support a proper course of treatment – limited to one during any 36 month period.

B. films, complete series, when required to support a proper course of treatment – limited to one during any 36 month period.

C. occlusal films.

D. extra-oral.

E. posterior bitewing films – limited to two per benefit Year.

F. sialography.

G. panoramic film, when required to support a proper course of treatment – limited to one during any 36 month period.

H. interpretation of radiographs from another source – per unit of time.

I. tomography.

5. preventive services

A. scaling and polishing – limited to one during any 9 month period.

B. topical fluoride treatment when required to support a proper course of treatment – limited to one during any 9 month period.

C. oral hygiene instruction – limited to one such instructional session per benefit Year.

D. pit and fissure sealants for Children under the age of 15.

E. caries control.

F. enameloplasty.

G. space maintainers (not involving movement of teeth).

MODULE B – RESTORATIVE AND SOME SURGICAL PROCEDURES

Covered Percentage – 90% without a deductible

Charges for

1. treatment of dental caries (fillings)
   - A. amalgam restorations of
     - (a) primary teeth.
     - (b) permanent anterior and bicuspid teeth.
     - (c) permanent molar teeth.
   - B. pin reinforcement.
   - silicate restorations.
   - D. acrylic or composite restorations.
   - E. occlusal equilibration – limited to 8 units of time during any 12 month period.

2. surgical services – removal of teeth
   - A. uncomplicated removal of erupted tooth
     - (a) primary teeth.
     - (b) each additional tooth in same surgical site.
   - B. surgical removal
     - (a) removal of erupted tooth (complicated).
     - (b) removal of impacted tooth.
   - C. removal of residual roots
     - (a) soft tissue coverage.
     - (b) bone tissue coverage.
   - D. anaesthesia.
   - E. professional visits.

MODULE C – ADDITIONAL RESTORATIVE AND SURGICAL PROCEDURES

Covered Percentage – 90% without a deductible

Charges for

1. periodontal services (diagnosis and treatment of gum tissue)

   A. non-surgical services – per unit of time

      (a) application of displacement dressing.

      (b) management of acute infections and other oral lesions.

      (c) desensitization of tooth surface.

   B. surgical services

      (a) gingivoplasty.

      (b) gingivectomy.

      (c) osseous surgery.

      (d) osseous grafts – single, multiple site.

      (e) soft tissue grafts.

      (f) vestibuloplasty.

      (g) post surgical treatment – periodontal – per unit of time.

   C. adjunctive periodontal services

      (a) provisional splinting – intra coronal, extra coronal – per unit of time.

      (b) periodontal scaling and root planing – per unit of time.

      (c) myofacial pain syndrome appliance (when not related to TMJ dysfunction).

      (d) special periodontal appliances (including occlusal guards).

      (e) periodontal re-evaluation.

2. endodontic services

A. pulp capping.

B. vital pulpotomy.

C. pulpectomy.

D. root canal therapy.

E. apexification.

F. periapical services.

G. root amputation.

H. gingival curettage.

I. alveoplasty – per unit of time.

J. banding of tooth to maintain sterile operating field (isolation of endodontic tooth).

K. hemisection.

L. intentional removal, apical filling and reimplantation.

M. opening and drainage.

N. emergency procedures.

O. apical curettage.

3. surgical services

A. fibrotomy.

B. surgical exposure of a tooth.

C. surgical repositioning of a tooth.

D. enucleation of an unerupted tooth and follicle.

E. gingivoplasty and/or stomatoplasty.

F. osteoplasty – per unit of time.

G. tuberoplasty.

H. removal of excess mucosa.

I. removal of cyst.

J. repair of soft tissue.

K. surgical excision.

L. surgical incision.

M. fractures.

N frenectomy.

O. miscellaneous surgical services.

P. adjunctive general services – drugs (injections).

MODULE D – PROSTHODONTIC PROCEDURES

Covered Percentage – 90% without a deductible for items 1, 2 and 3 and 50% without a deductible for all other items.

Charges for

1. denture adjustments
2. denture repairs
3. denture rebasing, relining (once every 3 years)
4. gold foil restorations
5. gold and porcelain inlays
6. recementing of inlays and onlays
7. removal of inlays and onlays
8. retention pins, posts and cores
9. exams, films and casts
10. retainers
11. bridges, and repairs to bridges including abutments and pins
12. crowns and repairs to crowns. Charges for a replacement crown are not considered an

Eligible Expense unless the existing crown is at least 5 years old and cannot be made serviceable

13. recementing of crowns
14. removal of crowns
15. complete maxillary denture
16. complete mandibular denture
17. removable partial dentures

Charges for a replacement bridge or replacement standard denture, are not considered an Eligible Expense, unless:

A. it is needed as a result of the removal of additional natural teeth after insertion of the existing bridge or standard denture,

B. the existing bridge or standard denture is at least 5 years old and cannot be made serviceable,

C. the existing bridge or denture was temporarily inserted, provided that the replacement bridge or denture is inserted within 12 months of the temporary bridge or denture and the replacement will thereafter be deemed permanent for the purposes of this provision,

D. the replacement bridge or denture is required as the result of the insertion of an initial opposing denture after the date the person becomes covered under this Plan, or

E. the replacement bridge or denture is required as the result of accidental dental injury to a natural tooth that occurred after the date the person becomes covered under this Plan.

MODULE E – ORTHODONTIC PROCEDURES

Covered Percentage – 50% without a deductible

Available to Employees and Dependents.

Charges for

1. observation and adjustment

A. orthodontic exam

B. films

C. orthodontic diagnostic casts

D. surgical services

E. observation and adjustment

F. repairs, alterations

2. appliances

A. removable appliances

B. fixed appliances

C. retention appliances

D. appliances to control harmful habits

Pre-Determination

If the expected cost exceeds $300, you should submit the Dentist's proposed treatment plan (completed dental claim form) to Sun Life before treatment commences. Sun Life will advise you the amount payable for the treatment taking into account possible alternate procedures or course of treatment based on accepted dental practice. This will make you aware of the amounts payable before the dental work is done.

Alternate Procedures

When deciding what will be paid for a procedure, Sun Life 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. Sun Life will not pay more than the reasonable cost of the least expensive alternate procedure.

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

Limitations

Payment is not made for

1. 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.
2. any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

Exclusions

A benefit is not paid for

1. services and supplies related to the purchase, repair, modification or replacement of a duplicate prosthetic appliance, for any reasons.
2. charges for appointments not kept or completion of claim forms.
3. expenses related to services or supplies of the type normally intended for sport or home use, such as but not limited to, mouthguards.
4. charges for dental services due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.
5. the portion of any charge which is the legal liability of another party.
6. any service or supply for which there would be no charge in the absence of this coverage.
7. user fees, co-insurance charges or similar charges which are in excess of charges payable by a government dental, hospital or health plan.
8. dental treatment which is not yet approved by the Canadian Dental Association or which, in the opinion of the Plan Administrator, is clearly experimental in nature.
9. services and supplies which, in the opinion of the Plan Administrator, are rendered principally for cosmetic purposes including, but not limited to, porcelain or composite facings on crowns or bridges on molar teeth.
10. services rendered and supplies purchased prior to the date the person became covered under this Plan.

11. charges for appliances or modification of appliances where an impression is made for such appliance or modification before the person became covered under this Plan, charges for crowns, bridges and gold inlays for which a tooth was prepared before the person became covered under this Plan or charges for root canal therapy where the pulp chamber was opened before the person became covered under this Plan.
12. services and supplies rendered as a result of a congenital or developmental malformation which is not a Class I, II or III malocclusion.
13. charges for a periodontal appliance, occlusal equilibration, and other related services as a result of a temporo-mandibular joint dysfunction (TMJ dysfunction) or vertical dimension correction.
14. charges for orthodontic treatment, for an Employee or his Spouse, where the initial appliance was installed before the date the person became covered under this Plan.

Making a Claim

If you or any of your Dependents incur Eligible Expenses while insured, a claim must be made not later than 15 months after the earliest of the following dates:

1. the date you incur the expenses
2. the termination of your insurance, and
3. the termination of this provision.

You incur an Eligible Expense on the date

1. a single appointment procedure is performed.
2. a multiple appointment procedure is completed.

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).

This group plan arranged by:
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