Sun Life Financial

your group benefits

York University

CUPE 1356-1 (Parking and Security Services)
Health, Dental, Life Insurance and Long-Term Disability Plans

Contract Number 14098, 50813 and 56255
Effective October 1, 2012 (Version 2)

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General Information

About this booklet

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

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

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

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

- Extended Health Care
- Emergency Travel Assistance
- Dental Care

This means York University 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 24 hours a week.

There is no waiting period for your group plan.

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

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

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who 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 (age 26 for employees residing in Québec) as long as the child is entirely dependent on you for financial support.

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

- the child is incapable of financial self-support because of a

physical or mental disability, and

- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

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

Enrolment

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

When coverage begins

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

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

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

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

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

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

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exceptions apply if the result of the change is an increase

in coverage:

- if you are not actively working when the change occurs 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

As required by legislation, for insured benefits, if you reside in Alberta or British Columbia, 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 for any reason other than retirement on pension.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

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

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

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions for insured benefits

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for disability benefits that have been paid by Sun Life for some period of time, more than one year after the last date for which disability benefits have been paid, or
- regarding all other claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim.

Legal actions for self-insured benefits

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

Coordination of benefits

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

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

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

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

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

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

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

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

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.

- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

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

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

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

Medical examination

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

Recovering overpayments

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

Definitions

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

Accident

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

Appropriate treatment (For Long-Term Disability)

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

For Life Coverage

Basic earnings are the salary or wage you receive from your employer including any stipends but excluding any bonus or overtime pay.

If you are on an approved leave of absence with or without pay, on sabbatical leave or reduced workload, the basic earnings shall be the greater of your annual basic earnings immediately prior to such leave or reduction in workload, or your annual basic earnings that you would have received if at work full time and for full pay at the date of death.

For Long-Term Disability

Basic earnings are the salary you receive from your employer including any stipends but excluding any bonus, overtime or other special compensation.

Disposable Income

The employee's basic earnings on the date of disability less the following deductions that are remitted by the employer to a third party (federal and provincial income tax based on the tax status at the date of disability, York University Pension plan contributions and Canada Pension Plan).

- Federal and provincial income tax based on current taxation status determined in accordance with the Tax Credit Return filed by the employer limited to:
  - Basic Personal Amount
  - Married and supporting a spouse
  - Single, divorced, separated or widowed and supporting a dependent
  - Claim for Wholly Dependent Children
  - Claim for Other dependents

- York University Pension Plan contributions as defined in the plan text

- Canada Pension Plan

Classes ***Class L*** – CUPE 1356-1
Class K1 – Retired CUPE 1356-1 and their survivors

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

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

Retirement date If you are totally disabled, your retirement date is July 1st following your 65th birthday, except those born on July 1st , in which case the retirement date is your 65th birthday.

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

Extended Health Care
(Medicare Supplement)

Plan administrator

This benefit is administered by Sun Life Assurance Company of Canada on behalf of York University.

General description of the coverage

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

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *Medically necessary* means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

An expense must be claimed within 15 months from the date 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 $25 each benefit year for each person up to a maximum of $25 per family. After this deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

For hospital expenses in your province, hearing aids and vision care

there is no deductible.

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

The prescription drug deductible ceases to be applied for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached.

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

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 covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins. Syringes for self-administered injections are also covered.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies including syringes, needles, alcohol, swabs, lancets and test strips.
- Autolet / Monolet (blood letting device) including platforms.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of $500 for each person.
- vaccines used to prevent disease or for travel purposes and

toxoids, up to a maximum of $300 per family in a benefit year.

- drugs for the treatment of weight loss. Prior approval is needed provided you meet the BMI requirement.
- drugs for the treatment of sexual dysfunction, up to a maximum of $1,200 per person in a benefit year.
- intrauterine devices (IUDs) and diaphragms.
- oral contraceptives.
- colostomy and ileostomy supplies.
- varicose vein injections.

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period as ordered by a doctor.

We will also cover 50% of the cost, after you pay the deductible for insulin injector/medijector, up to a maximum of $350 per person in a benefit year.

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 proteins and food or dietary supplements.
- hair growth stimulants.
- drugs for the treatment of infertility.
- 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.

Dispensing fee

Eligible expenses for the dispensing fee are limited to $8 for each prescription or refill, and are covered at 100%.

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 semi-private 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 120 days for treatment of an illness due to the same or related causes. The deductible does not apply to these expenses.

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

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

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

Expenses out of your province

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

For emergency services we will cover the cost of:

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

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

Emergency services

We will pay 100% of the cost of covered emergency services after you pay the deductible.

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

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ Assistance prior to being

performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

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

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

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

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

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

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Emergency services excluded from coverage

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

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

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $10,000 per person or, if lower, any other applicable lifetime maximum.

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. There is a lifetime maximum of $10,000 per person.

Nursing pre-care assessment

To establish the amount of coverage available under this plan before private duty nurse services begin, you should apply for a pre-care assessment.

To receive a pre-care assessment, you must ask your attending doctor to complete the nursing questionnaire that is available from your employer and submit it to Sun Life.

Your attending doctor will be required to provide information such as:

- a description of your current medical condition and prognosis.
- a list of the required nursing services and their frequency.
- the level of care required to perform the required services, meaning those of a registered nurse, registered nursing assistant or other practitioner.
- the number of hours of care required per day and the number of days per week.
- the expected duration of care.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- the following services for diagnostic and screening purposes rendered in a public or private laboratory, up to a combined maximum of $300 per family per benefit year, provided that the covered person's provincial plan does not pay for these services:

  - laboratory tests.

  - ultrasounds.

  - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services.

- PSA (Prostate Cancer Screening Tests), limited to 1 per person in a 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, limited to 1 visit per person in a benefit year. The deductible does not apply to these services.

- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of $100 per eye.

- wigs required for permanent hair loss as a result of any injury or disease, or for temporary hair loss as a result of medical treatment for any disease, up to a maximum of $750 per person in a benefit

year. Wigs do not require a doctor's order.

- Mozes detector, limited to a 3 month supply in a persons lifetime.
- enuresis equipment/monitor, up to a maximum of $100 per person in a benefit year.
- diabetic supplies, including Novolin-Pens or similar insulin injection devices using a needle and insulin infusion sets excluding infusion pumps.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs.(eg. hospital beds, bed rails, trapeze bars, head halters and traction apparatus if ordered by a doctor. Air-fluidized hospital beds are excluded.) 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.
- mechanical lifts/hydraulic lifts.
- stimulator (bone growth, muscle) and supplies.
- external electrospinal stimulators for the correction of scoliosis.
- prone standers.
- braces and cervical collars. Braces are wearable, orthopaedic appliances that rely on a rigid material such as metal or hard plastic to hold part of the body in the correct position.
- casts, splints (including shoes attached to a splint) or trusses. Intra-oral splints are excluded.
- canes , crutches, walkers and parapodiums.
- pressure garments for burn patients.
- dressing/bandages.

- breast prostheses required as a result of surgery. If internal breast prostheses are provided, we will cover the costs based on coverage for external breast prostheses.
- artificial limbs, including repairs.
- artificial eyes, including rebuilding and polishing of artificial eye.
- myoelectric appliances, up to a maximum of $10,000 per prostheses.
- shoulder harnesses.
- cleft palate obturators.
- stump socks, up to a maximum of 6 pairs per person in a benefit year.
- elastic support stockings, up to a maximum of 2 pairs, per person in a benefit year.
- pressure gradient hose, up to a maximum of 3 pairs, per person in a benefit year.
- compression hose, limited to 3 pairs per person, up to a maximum of $300 in a benefit year.
- custom made pressure supports for lymphedema.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, chiropractor, podiatrist or chiropodist, up to a maximum of $500 per person in a benefit year.
- custom fitted orthopaedic shoes and modifications to orthopaedic shoes when prescribed by a doctor, chiropractor, podiatrist or chiropodist, up to a maximum of $100 per person in a benefit year.
- hearing aids (excluding batteries, tubing and ear molds) when prescribed by an ear, nose and throat specialist, up to a maximum

of $500 per person every 36 months. Repairs and maintenance are included in this maximum. The deductible does not apply to these expenses.

- radiotherapy or coagulotherapy.
- plasma and blood transfusions.
- oxygen and the equipment needed for its administration.
- breathing unit, respirator.
- monitors (breathing-apnea).
- constant positive airway pressure (CPAP). Supplies are limited to once in every six month period.
- inhalation appliance/device for drug administration, Maxi Mist nebulizer.
- chest percussors, drainage boards and sputum stands.
- suction pumps.
- tracheostoma tubes.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a maximum of $200 per person in a benefit year.
- insulin pumps, limited to 1 pump over a period of 5 benefits years.
- extremity pump for lympedoma or severe postphlebitic syndrome.
- catheter and catheterization supplies.
- speech aids such as Bliss boards and communication aids, when no alternative method of communication is possible.
- obus forme back support.

- food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.

We will also cover 50% of the cost of TENS machine.

Paramedical services

We will cover 100% of the costs after you pay the deductible, up to the limits specified below per person per specialty:

- licensed psychologists, up to a maximum of $1,000 in a benefit year.
- licensed massage therapists, limited to $81 per visit, up to a maximum of $400 in a benefit year.
- licensed speech therapists (treatment of speech impairments), up to a maximum of $300 in a benefit year.
- licensed physiotherapists (treatment of movement disorder), up to a maximum of $50 per visit.
- licensed naturopaths, up to a maximum of $400 in a benefit year.
- licensed osteopaths or osteopathic practitioners, up to a maximum of $300 in a benefit year.
- licensed chiropractors (treatment of muscle and bone disorder), limited to $55 per visit, up to a maximum of $400 in a benefit year, including a maximum of one x-ray examination each benefit year.
- licensed podiatrists (treatment of foot disorders) or chiropodists, up to a maximum of $300 in a benefit year.
- Christian Science Practitioners who are listed in the current Christian Science Journal.
- charges for athletic therapists (treatment of movement disorders) who are a member of Canadian Athletic Therapists Association, up to a maximum of $300 in a benefit year.

We will not pay for the cost of services rendered by a podiatrist in Ontario unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

We will not pay for the cost of services rendered by a chiropractor or a podiatrist in Alberta unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

Contact lenses or eyeglasses

We will cover the cost of contact lenses or eyeglasses. Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician.

We will cover 100% of these costs up to a maximum of $400 in any 24 month period starting with December 1, 2005.

The deductible does not apply to eyeglasses or contact lenses.

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

When coverage ends

Extended Health Care coverage will end when the employee retires.

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 a claim no later than the earlier of:

- 15 months from the date in which you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage.

Dental Care

Plan administrator

This benefit is administered by Sun Life Assurance Company of Canada on behalf of York University.

General description of the coverage

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

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

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

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide approved by the provincial Dental Association for that specialist will be used.

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

When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will reimburse you for the reasonable cost of the least expensive alternate procedure that will obtain a professionally adequate result.

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

An expense must be claimed within 15 months from the date 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

We will not pay more than:

- $1,500 per person for Preventive and Basic dental procedures combined.
- $2,500 per person for Major dental procedures (excluding Dentures).

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

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $5,000.

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Preventive dental procedures

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

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

Oral examinations

1 complete examination every 6 months. A complete examination includes complete examination and charting of the hard and soft structures, periodontal charting, pulp vitality tests, recording history, treatment planning, case presentation and consultation with the patient.

1 recall examination every 6 months. Recall and specific examinations include a complete examination of the hard and soft structures, checking occlusion, pulp vitality tests and consultation with the patient.

Your are also covered for emergency or specific examinations:

- an emergency examination includes an evaluation for acute pain or infection, and pulp vitality tests.
- specialty examinations and evaluation of a specific situation.

X-rays

1 complete series of x-rays or 1 panorex every 24 months. A complete series of x-rays (minimum of 16 films including bitewings), showing all the teeth in the mouth. A panorex is a large panoramic view of the entire mouth.

1 set of bitewing x-rays every 6 months. A bitewing x-ray is a routine check-up x-ray used to detect decay in molar teeth.

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

Other services

Required consultations between two dentists.

Topical fluoride treatment once every 6 months.

Polishing (cleaning of teeth) limited to 2 units every 6 months.

Emergency or palliative services.

Test and lab exams

Test and lab examinations covered by this benefit include microbiological tests, histological tests and cytological tests.

Extraction of impacted tooth

This procedure includes local anaesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation.

Space maintainers and maintenance

You are covered for this procedure when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth.

Pit and fissure sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming.

Caries, trauma and pain control

You are covered for sedative fillings that are applied to very deep cavities to reduce pain.

Oral hygiene instruction once every 6 months.

Harmful habit breaking and custom fluoride appliances.

Anaesthesia

Anaesthesia in conjunction with Preventive procedure covered under this plan.

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

You are covered for amalgam fillings (silver) and composite or acrylic fillings (white fillings) or equivalent.

An amalgam filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on 1 surface will be considered a single filling.

A composite or acrylic filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on 1 surface will be considered a single filling.

Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

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

Root canal therapy. This procedure includes treatment plan, pulp vitality test, opening and drainage, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, relieving occlusion, smoothing tooth, and follow-up care. If root canal therapy is performed on the same tooth by the same dentist within 3 months of opening and drainage, pulpotomy or pulpectomy, the amount payable is reduced by the amount previously paid for such opening and drainage, pulpotomy or pulpectomy.

Bleaching on endodontically treated teeth.

Apexification. This procedure includes treatment plan, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, placement of dentogenic media, and follow-up care. You are only covered for permanent teeth.

Apicoectomy. This procedure includes treatment plan, local anaesthesia, clinical procedure with appropriate x-rays, root resection, apical curettage, and follow-up care.

Retrofilling. This procedure includes apicoectomy, curettage and root-end filling.

Root amputation. This procedure includes recontouring tooth and furca.

Hemisection. You are covered for this procedure.

Vital pulpotomy. This procedure includes treatment plan, local anaesthesia, clinical procedure and appropriate x-rays, and follow-up care.

Bleaching. Treatment for discolored teeth.

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

Scaling and root planing **Tartar removal.** Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

Occlusal equilibration You are covered for treatments to adjust your bite. This treatment is only available when you have gum surgery or temporomandibular joint (TMJ) treatment.

TMJ treatment The hinge joint of the jaw is called the temporomandibular joint or TMJ.

Bruxism (grinding of teeth).

Oral surgery Surgery, other than the removal of impacted teeth (*Preventive dental procedures*) and implant related surgery (*Major dental procedures*). Oral surgery includes local anaesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation.

Repairing, relining or rebasing dentures Repairing dentures means fixing broken or damaged dentures.

Relining dentures means adding material so that the dentures fit properly. Rebasing dentures means fitting dentures with a new base.

Veneers. For teeth which have extensive incisal or cusp damage and cannot be restored by composite filling.

Anaesthesia Anaesthesia in conjunction with Basic procedure covered under this plan.

Major dental procedures

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

We will pay 75% of the eligible expenses for dentures and 70% for all other procedures.

Inlays and onlays

Inlays and onlays are metal or porcelain fillings placed on the surface of the tooth. Inlays and onlays are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

Inlays and onlays include treatment planning, occlusal records, local anaesthesia, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. Inlays are only covered when x-rays indicate a crown will be required. Onlays are limited to teeth with extensive incisal or cusp damage.

Crowns

This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. It includes porcelain crowns for molar teeth. Crowns are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

Repair

Repair of bridges.

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.

Implants **For implants installed in connection with a crown or a bridge.** For the implant and the related surgery and crown or bridge, we will pay the benefit that would have been payable under this plan for a non implant related bridge.

For implants installed in connection with a denture. For the implant and the related surgery and denture, we will pay the benefit that would have been payable under this plan for a non implant denture.

Anaesthesia Anaesthesia in conjunction with Major procedure covered under this plan.

Orthodontic procedures

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

We will pay 85% 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.

Anaesthesia Anaesthesia in conjunction with Orthodontic procedure covered under this plan.

When coverage ends

Dental Care coverage will end when the employee retires.

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

Payments after coverage ends

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

What is not covered

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- implants, transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

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

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

- 15 months from the date in which you incur the expenses, or
- 90 days after the end of your Dental Care coverage.

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

Health Spending Account (For Retirees Only)

Plan administrator

This benefit is administered by Sun Life Assurance Company of Canada on behalf of York University.

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 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. If a claim exceeds your account balance, the claim will be paid up to the amount in your account and returned to you. You should submit it again once you have the additional credits required. Expenses incurred in one benefit year for which credits have been allocated can 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 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.

Plan credits

$1,500 on the commencement of each benefit year

Surviving dependent coverage

If you die while covered by this plan, coverage for eligible dependents will continue until the following date:

- the date the person would no longer be considered your dependent under this plan if you were still alive, or
- the date the Health Spending Account benefit provision terminates.

However, the plan credits that will be allocated to the Health Spending Account will be as follows: $750 on January 1 following the date of your death, and thereafter $750 on the commencement of each benefit year for a maximum of 5 years.

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.

Other coverage

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

When and how to make a claim

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

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

- the end of the benefit year following the benefit year during which you incur the expenses, or
- the end of your Health Spending Account coverage.

Long-Term Disability

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to York University.

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 elimination period and the following 36 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 any and every duty 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.

If you have 35 or more years of employment with your employer, you will be considered totally disabled while you are prevented by illness from performing the essential duties of your own occupation.

If you must hold a government permit or licence to perform your own occupation and your permit or licence is withdrawn or not renewed solely for medical reasons, we will consider you totally disabled for up to 12 months after the end of the elimination period. You cannot be working other than in a Sun Life approved partial disability or rehabilitation program.

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.

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.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 90 days 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 or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 90 days and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

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

Step 1: We take 60% of the first $500 of your monthly basic earnings, add 50% of the balance of your monthly earnings, rounded to the next higher $1, up to a maximum benefit of $2,500.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under any government-sponsored plan, excluding dependent benefits, employment insurance benefits and automatic cost-of-living increases under any government-sponsored plan that occur after benefits begin.

- for any disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under a group plan, including any coverage resulting from your membership in an association of any kind.
- for any salary continuation plan of the employer, excluding vacation pay.
- for any benefits or increases in benefits under any group insurance contract or pension plan of the employer or other arrangement which is either sponsored or provided by any governmental or regulatory body or under which benefits are provided in the event of disability if such benefits commenced on or after the inception of a disability for which benefits are payable under this contract.
- for any benefits payable under any retirement plan if such benefit commenced on or after the inception of a disability for which benefits are payable under this contract.
- under the Québec Parental Insurance Plan.

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

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

We will not take into account any benefits that began before your disability began.

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

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 90 days, 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, vocational training or graduated return to work 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. However, the Long-Term Disability payments will be reduced by 50% of your pre-disability basic earnings you receive under the rehabilitation program (less provincial and federal income taxes if your benefit is non-taxable). If during any month your total income is more than 100% of your pre-disability basic earnings or disposable basic income, 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 all of the following conditions are met:

- the initial period of total disability lasts for at least 28 days without interruption.
- afterwards, there is no interruption of more than 30 days.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

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

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

Interrupted periods of disability after payments begin

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

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

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 36 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 36 months that benefits are payable.
- try to obtain work in another occupation after the first 36 months that benefits are payable.

- obtain benefits that may be available from other sources.

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

When payments end

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

- the date you are no longer totally disabled.
- the later of July 1 coincident with or next following the date the employees attains age 65, and
- the date the employee receives 12 monthly benefit payments, if age 64 when commencing benefit.
- the last day of the month in which you retire with a pension or are eligible to retire with a full pension or a full pension equivalent.
- the last day of the month in which you die.

When coverage ends

Long-Term Disability coverage will end on July 1 coincident with or next following the date the employee attains age 65 or on the day your 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 under the care of a doctor.
- that you do any work for wage or profit except as approved by Sun Life.
- you are on a leave of absence, strike or lay-off except as stated under *Maternity / parental leave of absence* or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any

reason, unless Sun Life agrees in writing in advance to pay benefits during the period.

- you are serving a prison sentence or are confined in a similar institution.

We will not pay benefits for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries or attempted suicide, while sane or insane.
- 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 60 days of the termination of this Long-Term Disability benefit.

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

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

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

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

Life Coverage

Insurer

This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Council of Ontario Universities.

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

Life coverage for you

For employees under age 65 and employees who attained age 65 on or after July 1st of the year immediately preceding the date of employment and before July 1st of the year of employment.

Amount

Your Life benefit is 3 times your annual basic earnings, rounded to the next higher $1,000 (if not already a multiple of $1,000). The maximum amount of coverage is $600,000.

Reduction

Your benefit will reduce to 1 times your annual basic earnings, rounded to the next higher $1,000 (if not already a multiple of $1,000) on July 1st coincident with or next following the date you reach age 65. The maximum benefit will be $600,000.

Coverage ends

Your coverage will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

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

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

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death

benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Converting Life coverage

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

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

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

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

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).

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.