

your **group**
benefits

York University

**Retired York University Faculty Association Employees (YUFA),
Retired York University Faculty Association Exempt
Employees (YUFAE) and their Survivors
Health and Dental Plans**

**Contract Number 14098
Effective May 1, 2013 (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 plan with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

Your group benefits may be modified after the effective date of this booklet. You will be informed of changes to your group plan. Any notification of changes or revised booklet describing your coverage should be kept in a safe place.

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 all benefits. This means York University has the sole legal and financial liability for all benefits and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

Eligibility To be eligible for group benefits, you must be a resident of Canada and have been covered under your employer's group plan on the day preceding your retirement.

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

When coverage begins

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

Dependent coverage begins on the date your coverage begins.

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.

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.

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.

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

However, if you die while covered by this plan, Extended Health Care and Dental Care coverage for your dependents will continue with premium payments until the earlier of the following:

- the date the person would no longer be considered your dependent if you were still alive.
- the date in which your dependent dies.
- the due date of the first premium to which a required contribution has not been paid for dependent coverage.

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.

**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.

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.

Classes **Class C** – Retired York University Faculty Association Employees (YUFA) and their survivors.
Class C1 – Retired York University Faculty Association Exempt

Employees (YUFAE) 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.

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

Extended Health Care (Medicare Supplement)

General description of the coverage

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 \$130 each benefit year per individual.

For hospital expenses in Canada and hearing aids there is no deductible.

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

If 2 or more members of your family suffer injuries in the same

accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.

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

Prescription drugs

After you pay the deductible, we will cover 80% 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 for the treatment of the conditions listed:
 - anemia – single entity iron salts;
 - convulsions – anti-convulsants;
 - eye disease – mydriatics, cycloplegics, miotics, glaucoma therapy drugs;
 - heart disease – anti-anginal agents, anti-arrhythmic agents, cardiotonics, vasodilators, vasopressors, potassium replacements;
 - lung disease – bronchodilators, mucolytics, parasympathomimetics, tuberculosis therapy drugs;
 - Parkinson's disease anti-parkinsonians, anticholinergic/antispasmodic agents, and;
 - thyroid disorders – hyperthyroidism drugs.
- intrauterine devices (IUDs), diaphragms, colostomy and ileostomy supplies.
- diabetic supplies including alcohol, swabs, lancets and test strips.
- drugs for the treatment of infertility.
- drugs for the treatment of weight loss. Prior approval is needed provided you meet the BMI requirement.

- Autolet / Monolet (blood letting device) including platforms.
- products to help a person quit smoking that legally require a prescription, limited to a 3 month supply, up to a lifetime maximum of \$500 per person.
- drugs for the treatment of sexual dysfunction, up to a maximum of \$1,200 per person in a benefit year.
- injectable drugs. Syringes for self-administered injections are also covered.
- drugs for the treatment of sexual dysfunction.

We will also cover 80% 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 only pay for quantities that can reasonably be used in a 3 month period.

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

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

***Other health
professionals allowed
to prescribe drugs***

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

**Hospital expenses in
your province**

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and a private hospital room up to a maximum of 120 days per stay.

We will also cover the difference between the cost of a ward and a private hospital room 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 and it follows at least 3 consecutive days of in-patient hospitalization.

The lifetime maximum is 120 days for treatment of an illness due to the same or related causes.

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.

***Homewood Health
Centre***

We will cover 100% of the cost of treatment received in Homewood Health Centre provided:

- the provincial health care plan pays the equivalent of ward level accommodation,
- the treatment has been approved by your employer.

The maximum amount payable is the difference between the cost of a ward and a private room. The deductible does not apply to these expenses.

**Expenses out of
your province/out of
Canada**

We will cover emergency services while you are outside the province where you live and out of Canada.

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
outside your
province/within
Canada*

We will pay 100% of the cost of covered emergency services outside your province / within Canada. The deductible does not apply to these expenses.

*Emergency services
outside Canada*

We will pay 80% of the cost of covered emergency services outside Canada, 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 \$20,000 per person or, if lower, any other applicable lifetime maximum.

**Medical services and
equipment**

We will cover 80% 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. The lifetime maximum is the lesser of 120 days or \$10,000.

*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.

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- 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 \$200 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.
 - 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.
 - contact lenses or intraocular lenses following non-refractive eye 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.
- TENS machine.
- 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 electrosinial 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 and pressure gradient hose, up to a maximum of 3 pairs per type, per person 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.
- 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) prescribed by an ear, nose and throat specialist, when required due to hearing loss as a result of an accident – the accident must

occur while you are covered under this plan and notification of the accident must be submitted to Sun Life with 12 months of the accident occurring. 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 lymphedoma 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.

Paramedical services

We will cover 80% of the costs after you pay the deductible, up to the limits specified below per person per specialty:

- licensed psychologists.
- licensed physiotherapists (treatment of movement disorder).
- licensed naturopaths.
- licensed osteopaths or osteopathic practitioners.
- licensed chiropractors (treatment of muscle and bone disorder), limited to \$6 per visit, up to a maximum of \$120 per person in a benefit year.
- licensed podiatrists (treatment of foot disorders) or chiropodists.
- Christian Science practitioners who are listed in the current Christian Science Journal.

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 podiatrist in Alberta unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

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,

**When and how to
make a claim**

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

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

**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 not pay more than the reasonable cost of the least expensive alternate procedure. However, we will not alternate porcelain facings on pontics and retainers on molar teeth.

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 \$1,250 per person for each benefit year for all services.

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 24 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.

You 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.

Provision of space maintainers for missing primary teeth.

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.

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.

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.

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.

Gold foils and tooth-coloured veneer applications.

We will pay 50% of the eligible expenses for the following procedures:

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

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

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.

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 85% of the eligible expenses for these 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.

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

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.

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

Information.

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.

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.

