

Trent University
Non-Academic Employees

Contract Number 50490
Effective September 1, 2004

Table of Contents

Benefit Details.....	1
General Information	8
Life Insurance.....	10
Survivor Income Insurance	11
Long Term Disability	12
Hospital Insurance	15
Supplemental Health Care	17
Emergency Travel Assistance Benefit (Medi-Passport).....	24
Dental Insurance	32

Benefit Details

INSURANCE BENEFITS FOR YOU

LIFE INSURANCE

<u>Basic Amount</u>	1 1/2 times your annual Basic Earnings.
<u>Optional Amount</u>	1, 2, 3 or 4 times your annual Basic Earnings, whichever you elect.

The maximum amount of your Basic and Optional Insurance combined is \$1,000,000.

You may change your election of Optional Insurance. Any increase in the amount because of such change must be approved by Sun Life, except such approval is waived if you increase your Optional Insurance on the date you first acquire a Dependent and you request such increase not later than 31 days after acquiring the Dependent.

This benefit ends on the earliest of:

1. the last day of the month in which you attain age 65.
2. the date you retire.
3. the date your employment terminates.
4. if you are appointed on a limited term basis, the date the term appointment expires.

SURVIVOR INCOME INSURANCE

	<u>Amount</u>
Spouse only	25% of Insured Earnings
Spouse and Children	25% of Insured Earnings plus 15% of Insured Earnings. If you and your Spouse die in the same accident, the Children's benefit payable will be 25% of Insured Earnings
Children only	25% of Insured Earnings whichever you elect.
Insured Earnings	Your monthly Basic Earnings but not more than \$15,833.

4. if you are appointed on a limited term basis, 2 years after the term appointment expires.

This benefit ends on the earliest of:

1. the last day of the month in which you attain age 65.
2. the date you retire.
3. the date your employment terminates.
4. if you are appointed on a limited term basis, the date the term appointment expires.

HEALTH INSURANCE BENEFITS FOR YOU AND YOUR DEPENDENTS

HOSPITAL INSURANCE

Note: Not available to any Employee or Dependent not entitled to benefits under any Provincial Medicare Plan or a Federal Government Plan which provides similar benefits.

Benefit Year – January 1st to December 31st.

Insured Percentage 100%

Maximum Benefit Unlimited

This benefit ends on the earliest of:

1. the last day of the month following the month in which you attain age 65.
2. the last day of the month following the month in which you retire.
3. the last day of the month following the month in which your employment terminates.
4. if you are appointed on a limited term basis, the last day of the month following the month in which the term appointment expires.

SUPPLEMENTAL HEALTH CARE INSURANCE

Note: Not available to any Employee or Dependent not entitled to benefits under any Provincial Medicare Plan or a Federal Government Plan which provides similar benefits.

Benefit Year – January 1st to December 31st.

Insured Percentages and other details

Type 1 – Hospital expenses in your Province of residence – for item 1 – 100% without a Deductible and for all other items – 100% in excess of the Deductible.

Type 2 – Prescription Drugs – 100% in excess of the Deductible.

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.

<u>Deductible</u>	Nil
<u>Pre-Determination Limit</u>	\$500
<u>Maximum Benefit</u>	Unlimited (other than orthodontic procedures) \$2,000 lifetime (orthodontic procedures)

This benefit ends on the earliest of:

1. the last day of the month following the month in which you attain age 65.
2. the last day of the month following the month in which you retire.
3. the last day of the month following the month in which your employment terminates.
4. if you are appointed on a limited term basis, the last day of the month following the month in which the term appointment expires.

CHANGES IN AMOUNTS

Your insurance may change if your status affecting the insurance changes. Such change is made on the day your status changes.

Note:

Unless you've been granted a leave of absence, if you are not Actively At Work (i) on the date an increase in your Amount Of Insurance under the Employee Life, Survivor Income or Long Term Disability Benefit would otherwise take effect, or (ii) on the date the Group Policy is amended to provide additional benefits or increased Employee Life, Survivor Income or Long Term Disability Benefits, any increase will only take effect on the first day you are Actively At Work.

DEFINITIONS

The group policy contains a number of definitions not listed here. The following definitions will be of greatest interest to you.

Note: All terms which are defined in the group policy are capitalized throughout the text of this folder.

Employee – Members of the Employer's non-academic staff, who are members of the bargaining unit represented by the Ontario Public Service Employees Union (or successor organization or equivalent), and who are either full-time, full-time recurring or part-time members. Part-time members must be scheduled to work at least 17 1/2 hours per week. Also eligible are non-academic staff who are on contract for at least one year and working half-time or more, with approval from the Employer. Any other persons designated by the Employer, in writing, to Sun Life.

Dependent – a Spouse or a Child who is a resident of Canada or the United States.

Spouse - 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 and has been for at least the previous year, publicly maintained and represented as your spouse, but only if certain conditions are met. Your Employer can supply precise details.

Child – your or your Spouse's child who is not married or in any other formal union recognized by law, excluding a child who has attained age 21 (age 25 in the case of a full-time student attending an educational institution recognized by the Income Tax Act (Canada) and is entirely dependent on you for financial support).

A handicapped Child who attains the limiting age may continue coverage as a Dependent if certain requirements are met. Your Employer can supply precise details.

Illness – bodily injury, disease, mental infirmity or sickness.

Totally Disabled – you are Totally Disabled if you are in a state of incapacity due to Illness which

1. while it continues during the Elimination Period and the following 24 months, prevents you from performing the essential duties of your own job at the onset of disability, and
2. while it continues after such period, prevents you from earning at least 66 2/3% of your Basic Earnings at the beginning of your Elimination Period.

If you have 35 or more years of Employment, Totally Disabled is defined, until the end of the Maximum Benefit Period, in accordance with 1 above.

A Dependent is Totally Disabled if the Dependent is prevented by Illness from performing the Dependent's normal duties.

Appropriate Treatment - treatment which meets all the following conditions:

1. it is performed and prescribed by a Doctor, or when deemed necessary by Sun Life by a medical specialist;

2. it is of a reasonable and customary nature and treatment is provided with a frequency usually required for the condition;
3. it is not limited to solely examinations and/or testing.

Deemed Date of Retirement – If you become Totally Disabled, your date of retirement is deemed to be the last day of the month in which you attain age 65 unless you actually retire earlier.

Waiting Period – the period from the date of Employment up to and including the last day of the same month.

If you are employed on the first day of any month you are considered to have satisfied the Waiting Period for the Employee Life, Survivor Income and Long Term Disability Benefits by the date of your Employment.

For Hourly Employees – 3 months of continuous employment.

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 there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority.

Insurance Coverage Begins

Your and your Dependent's insurance begins on the day following your completion of the Waiting Period (see the Benefit Details) provided you enrol without delay. Otherwise evidence of insurability may be required before you and your Dependents can join the plan. A Certificate showing your insured benefits and effective date of cover will be issued to you. If you acquire your first Dependent after the effective date of your insurance, you must make an application within 31 days of acquiring your first eligible Dependent to have your Dependent insured. Application for Survivor Income Insurance should also be made if such Dependent qualifies as a Survivor. Otherwise evidence of insurability may be required before your Dependent may be insured or you may become covered for Survivor Income Insurance. Any subsequent Dependent will become insured without formal application.

If you are not Actively At Work on the effective date indicated on the Certificate, your coverage is delayed until the day you are Actively At Work.

Insurance Coverage Ends

Your insurance ends on the earliest of:

- the date your Termination Of Employment occurs,

- the end of the period for which premium is paid for your insurance,
- the date the group policy is no longer in force,
- the date you cease to have a person who qualifies as a Survivor (Survivor Income Insurance only).

Insurance on your Dependent ends on the earliest of:

- the date your insurance ends,
- the date the definition of a Dependent is no longer met,
- the last day of the third month following the month in which you die,
- the end of the period for which premium is paid for Dependent insurance.

Making a Claim

Sun Life is dedicated to prompt and efficient claim service. When a loss that is eligible for payment is incurred, a completed claim form together with the required proof (see the claim form) should be forwarded to Sun Life. Claim forms are available from your Employer. Time limits for making a claim are shown in the following benefit descriptive pages.

Subrogation

If you are entitled to recover damages for loss of income from another person as a result of personal injuries sustained by you and for which you are entitled to receive benefits under the Long Term Disability Insurance Benefit Provision, Sun Life will be subrogated to all your rights of recovery for loss of income to the extent of the sum of the benefits paid or payable to you under that provision.

Sun Life may, in connection with its right of subrogation, require that you complete a Reimbursement Questionnaire and execute a Reimbursement Agreement. If you do not complete and return to Sun Life the Reimbursement Questionnaire or do not execute and return to Sun Life the Reimbursement Agreement within 30 days after a request that you complete or execute it, the benefits which you would otherwise be entitled to receive under the Long Term Disability Insurance Benefit Provision will not be paid until you do so.

Life Insurance

The amount of your Life insurance can be determined from the Benefit Details.

If you die while insured, Sun Life will pay the amount of your Life insurance to the last nominated beneficiary as filed. In the absence of a beneficiary nomination, payment will be made to your estate.

You may name the beneficiary of your choice or your estate. Any nominations you make are revocable, unless you stipulate otherwise or the law provides otherwise.

Disability Benefit

If you become Totally Disabled while insured, and before the last day of the month in which you attain age 65, or earlier retirement, your Life insurance will remain in force during your continued Total Disability without payment of premium. Any amount of insurance continued is subject to the terms of the group policy.

Conversion

If your insurance ends, you are entitled, during the 31 day conversion period, to purchase an individual life insurance policy from Sun Life under the terms of the Conversion contained in the group policy. No medical examination is required.

Making a Claim

If you die, a claim should be made as soon as reasonably possible.

If you become Totally Disabled, a claim must be made not later than 12 months after you stopped being Actively At Work. Each year Sun Life may require proof of your continued Total Disability.

Survivor Income Insurance

The amount of your Survivor Income insurance can be determined from the Benefit Details.

If you die while insured, Sun Life will pay, subject to Limitations, the amount of your Survivor Income insurance to your Spouse, if living, otherwise to your Children in equal shares. Payments are made monthly until your Spouse dies, or your last surviving Child no longer qualifies, if later.

Disability Benefit

If you become Totally Disabled while insured, and before your 65th birthday or your earlier retirement, your Survivor Income insurance will remain in force during your continued Total Disability without payment of premium. Any amount continued is subject to the terms of the group policy.

Conversion

If your insurance ends, you are entitled, during the 31 day conversion period, to purchase an individual life insurance policy from Sun Life under the terms of the Conversion contained in the group policy. No medical examination is required.

Limitation

Payment is not made to or in respect of a person who on the date of your death is not a Survivor.

Making a Claim

If you die, a claim should be made as soon as reasonably possible.

If you become Totally Disabled, a claim must be made not later than 12 months after you stopped being Actively at Work. Each year Sun Life may require proof of your continued Total Disability.

Long Term Disability

The amount of your Long Term Disability insurance, the Elimination Period, the Maximum Benefit Period and the Rehabilitation Expense Benefit can be determined from the Benefit Details.

If you become Totally Disabled while insured Sun Life will pay, subject to Maternity / Parental Leave of Absence, Limitations and Exclusions, a Long Term Disability benefit for each month you remain Totally Disabled after completion of the Elimination Period until the earliest of the following:

1. the date you cease to be Totally Disabled,
2. the date you are no longer under the care of a Doctor,
3. the date the Maximum Benefit Period is reached, and
4. when you refuse to be examined by a Doctor appointed by Sun Life.

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.

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 Benefit

If you become Totally Disabled, you are encouraged to participate in a program of retraining such as a period of part-time work performed for the purpose of becoming capable of full-time employment. During this period you may qualify for rehabilitation income. This income is available for a maximum of 24 months following the Elimination Period. For you to receive this income the program must be approved in writing by Sun Life. It is recommended that you consider engaging in a Rehabilitative Program as soon as possible after commencement of your Total Disability. This could be before your monthly payments commence.

Rehabilitation Expense Benefit – In addition you are entitled to a Rehabilitation Expense Benefit if approved in writing in advance by Sun Life.

Residual Benefit – If you continue to be Totally Disabled after a period of rehabilitation and you engage in any occupation or employment, you may be entitled to a monthly Residual Benefit of up to 30% of your Insured Earnings. This benefit is available for a maximum of 18 months.

If you have any questions concerning these benefits, do not hesitate to contact Sun Life's Rehabilitation Section through the nearest claims office.

Benefits After Insurance Ends

If this insurance coverage ends while you are Totally Disabled you will continue to receive benefits as if the coverage were still in effect.

Limitations

Payment is not made for

1. any period you are not receiving the Appropriate Treatment.
2. any period, longer than 4 months, while you are absent from Canada due to any reason, unless Sun Life agrees in writing in advance to pay benefits during such period.

Exclusions

A benefit is not paid for a Total Disability which is due to or results from

1. the hostile action of any armed forces, insurrection or participation in any riot or civil commotion.
2. intentionally self-inflicted injuries or attempted suicide (while sane or insane).
3. commission or attempted commission of a criminal offence by you.

Making a Claim

If you become Totally Disabled, Sun Life must be notified through your Employer of your condition at least 30 days before the end of your Elimination Period. Formal claim must be made not later than 90 days after you complete your Elimination Period.

Hospital Insurance

If, while insured, you or your Dependents incur any of the Eligible Expenses, Sun Life will pay a benefit subject to Limitations and Exclusions.

The Benefit Year can be determined from the Benefit Details.

Eligible Expenses

SUPPLEMENTARY HOSPITAL (for expenses in and out of Canada)

Charges for

1. confinement in a Hospital or a Convalescent Hospital, up to the Hospital's or Convalescent Hospital's semi-private rate.
2. confinement in a Hospital for chronic care, up to the Hospital's semi-private rate, for up to \$3.00 per day for a maximum for 120 days, in any Benefit Year.

Co-ordination of Benefits

If you or any of your Dependents are insured for similar benefits under any other group plan, payments under this plan may be limited, but only to the extent necessary to limit reimbursement from all group plans to 100% of actual expenses.

Benefits After Insurance Ends

If a person's coverage ends while such person is Totally Disabled, charges related to that Total Disability will be considered as Eligible Expenses for a further period of up to 90 days, but only if this provision continues in effect.

Limitations

Payment is not made for

1. services or supplies payable in whole or in part under any legislation, except to the extent that it permits excess payment.
2. any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.

3. services or supplies for which no charge would have been made in the absence of this coverage.

Exclusions

A benefit is not paid for charges incurred for an Illness due to or resulting from:

1. the hostile action of any armed forces, insurrection or participation in a riot or civil commotion,
2. any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation, or
3. commission or attempted commission of a criminal offence by the insured person.

Making a Claim

If you or any of your Dependents incur Eligible Expenses, while insured, a claim must be made not later than 90 days after the earliest of the following dates:

1. the end of the calendar year during which the expenses were incurred,
2. the termination of your insurance, and
3. the termination of this provision.

Supplemental Health Care

If, while insured, you or your Dependents incur any of the Eligible Expenses for medically necessary services or supplies in the treatment of an Illness, Sun Life will pay a benefit, subject to Limitations and Exclusions. After the application of the Deductible, if any, for each Benefit Year, the amount payable is determined by using the Insured Percentages shown for the types of expenses. A benefit is not payable for an Eligible Expense used to satisfy the Deductible, nor if the Maximum Benefit has been paid.

The Benefit Year, the Deductible, the Insured Percentages and the Maximum Benefit can be determined from the Benefit Details.

Eligible Expenses

TYPE 1 – IN-PROVINCE SUPPLEMENTARY HOSPITAL

Charges in your or your Dependent's Province of residence for

1. confinement in a Hospital, up to the difference between the Hospital's semi-private and private rate.
2. confinement in a private Hospital for up to \$10 per day, for a maximum of 120 days in any Benefit Year.
3. out-patient services in a Hospital.

TYPE 2 – PRESCRIPTION DRUGS

Charges for

1. drugs, serums and vaccines prescribed in writing by a Doctor or Dentist and dispensed by a licensed pharmacist.
2. contraceptives prescribed in writing by a Doctor.
3. insulin, including needles and syringes, and diagnostic aids.
4. colostomy supplies.
5. anti-obesity treatments, including drugs, proteins and dietary or food supplements, prescribed in writing by a Doctor.

6. any nicotine resin containing products prescribed in writing by a Doctor.
7. Viagra prescribed in writing by a Doctor. The maximum amount payable in any Benefit Year is \$1,200 for each person.

Certain drugs prescribed by other qualified health professionals will be covered 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.

Payment is not made for

1. cough medicines, baby foods and formula, minerals, proteins and collagen treatments.
2. any charge for administration of serums, vaccines and injectable drugs.
3. drugs, serums and vaccines dispensed by a Doctor or Dentist.
4. vitamins or vitamin preparations, unless injected.

The payment for a single purchase of a Type 2 Eligible Expense is limited to the cost of a supply which could reasonably be consumed or used within a 3 month period following such payment.

TYPE 3 – EXTENDED HEALTH CARE

All medical care except the services of a licensed optometrist, licensed ophthalmologist or Dentist must be ordered by a Doctor.

Charges for

1. use of a licensed ambulance for local transportation of the person to and from the nearest Hospital qualified to render the necessary medical services.
2. use of air ambulance for transportation of the person to the nearest Hospital qualified to render the necessary emergency medical services.
3. emergencies or referrals outside the person's Province of residence for the following services
 - A. confinement in a Hospital, up to the difference between the Hospital's semi-private rate and private rate.
 - B. other Hospital services provided out of Canada.
 - C. out-patient services in a Hospital.

D. services of a Doctor.

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

- A. must be rendered in Canada if such services (irrespective of any waiting lists) are available in Canada, or may be rendered out of Canada if such services are not available in Canada, and
- B. must be services for which the Provincial Medicare Plan of the person's Province of residence agrees, in writing, to pay benefits to such person as a result of the referral.

Eligible Expenses must be incurred within 60 days of the date the person leaves his Province of residence. If Hospital admittance takes place within such period, in-patient services are covered until the date of discharge.

- 4. services, while not confined in a Hospital, of a private duty registered nurse or registered trained attendant, not normally resident in the person's home. The maximum amount payable during any three consecutive Benefit Years is \$25,000 for each person.
- 5. laboratory tests done in a commercial laboratory for diagnosis of an Illness (but excluding any tests performed in a Doctor's office or a pharmacy).
- 6. services of a Dentist, including charges for braces or splints, for the repair or alleviation of damage to natural teeth resulting from an accidental blow to the mouth which occurs while the person is insured under this provision and provided the services are received within twelve months after the date of the accident. In no event will payment exceed the amount for the procedure in the Provincial Dental Association Fee Guide for a general practitioner which is current in your Province of residence on the date the treatment is received.
- 7. services of an ophthalmologist or a licensed optometrist. The maximum amount payable in any two consecutive Benefit Years is \$25 for each person.
- 8. services of a licensed physiotherapist, not normally resident in the person's home.
- 9. equipment rented (or purchased at Sun Life's option) for therapeutic use, including, but not limited to, a hospital bed, cane, walker, oxygen set, respirator or wheelchair.
- 10. casts, splints, trusses, braces, crutches, cervical collars, catheters, urinary kits or ostomy supplies (where a surgical stoma exists).

11. external mammary prostheses and surgical bras required as a result of surgery.
12. corrective prosthetic lenses and frames for persons who lack an organic lens or after cataract surgery, limited to once during each person's lifetime.
13. custom-made orthopaedic boots or shoes or adjustments to regular footwear.
14. artificial limbs and eyes including necessary replacements. In the case of myoelectric or sport prosthesis, payment shall be limited to the amount that would otherwise be paid for standard type artificial limbs.
15. treatment by the use of radiotherapy or coagulotherapy.
16. oxygen, plasma and blood transfusions.

TYPE 4 – EXTRA CARE

Charges for

1.
 - A. services of a licensed qualified speech therapist, not normally resident in the person's home, when ordered by a Doctor. The maximum amount payable in any Benefit Year is \$200 for each person.
 - B. services of a licensed psychologist. The maximum amount payable in any Benefit Year is \$200 for each person.
 - C. services of a licensed massage therapist when ordered by a Doctor. The maximum amount payable in any Benefit Year is \$200 for each person.
 - D. services of a licensed naturopath. The maximum amount payable in any Benefit Year is \$300 for each person.
 - E. services of a licensed chiropractor, including a maximum of one x-ray examination per Benefit Year. The maximum amount payable in any Benefit Year is \$500 for each person.
2. hearing aids prescribed in writing by an otolaryngologist, including repairs to hearing aids. The maximum amount payable in any 4 consecutive Benefit Years is \$500 for each person.
3. contact lenses or lenses and frames for eyeglasses. Safety glasses of any kind are excluded. Supplies must be prescribed in writing by an ophthalmologist or a licensed optometrist and must be dispensed by an ophthalmologist, a licensed optometrist or a qualified optician. The maximum amount payable in any 12 month period for each person is \$200, (\$250 effective July 1, 2005).

EMERGENCY SERVICES OUTSIDE THE PERSON'S PROVINCE OF RESIDENCE

Eligible Expenses for Emergency Services outside the person's Province of residence are subject to all the conditions indicated below.

At the time of an Emergency, the covered person or someone with the covered person must contact Sun Life's Emergency Travel Assistance provider, Worldwide Assistance Services, Inc. (Worldwide Assistance). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Worldwide 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 Worldwide Assistance cannot be made before services are provided, contact with Worldwide 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 the covered person is medically stable to return to the province where the person lives.

Emergency Services Excluded From Coverage

Any expenses related to the following Emergency Services are not covered:

1. services that are not immediately required or which could reasonably be delayed until the person returns to the province where the person lives, unless their medical condition reasonably prevents the person from returning to that province prior to receiving the medical services.
2. services relating to an Illness or injury which caused the Emergency, after such Emergency ends.
3. continuing services arising directly or indirectly out of the original Emergency or any recurrence of it, after the date that Sun Life or Worldwide Assistance, based on available medical evidence, determines that the person can be returned to the province where the person lives, and the person refuses to return.

4. services which are required for the same Illness or injury for which the person received Emergency Services, including any complications arising out of that Illness or injury, if the person had unreasonably refused or neglected to receive the recommended medical services.
5. where the trip was taken to obtain medical services for an Illness or injury, services related to that Illness or injury, including any complications or any Emergency arising directly or indirectly out of that Illness or injury.

Co-ordination of Benefits

If you or any of your Dependents are insured for similar benefits under any other group plan, payments under this plan may be limited, but only to the extent necessary to limit reimbursement from all group plans to 100% of actual expenses.

Benefits After Insurance Ends

If a person's coverage ends while such person is Totally Disabled, charges related to that Total Disability will be considered as Eligible Expenses for a further period of up to 90 days, but only if this provision continues in effect.

Benefits After Provision Termination

If this provision terminates while a person is in receipt of benefits under Type 3 item 6, then such person will continue to be entitled to those benefits as if this provision had not terminated.

Limitations

Payment is not made for

1. services or supplies payable in whole or in part under any legislation, except to the extent that it permits excess payment.
2. any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.
3. services or supplies for which no charge would have been made in the absence of this coverage.

Exclusions

A benefit is not paid for

1. charges incurred for an Illness due to or resulting from:
 - A. the hostile action of any armed forces, insurrection or participation in a riot or civil commotion,
 - B. any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation, or
 - C. commission or attempted commission of a criminal offence by the insured person.
2. charges for equipment deemed by Sun Life not to be Eligible Expenses, (e.g. orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers).

Making a Claim

If you or any of your Dependents incur Eligible Expenses, while insured, a claim must be made not later than 90 days after the earliest of the following dates:

1. the end of the calendar year during which the expenses were incurred,
2. the termination of your insurance, and
3. the termination of this provision.

Emergency Travel Assistance Benefit (Medi-Passport)

This benefit, which supplements the Emergency portion of the out of province coverage under the Medicare Supplement Insurance, is available to you or your Dependents provided you are insured for the Medicare Supplement Insurance.

The Emergency Services excluded from coverage, and all other conditions, limitations and exclusions applicable to the Medicare Supplement Insurance Benefit also apply to Medi-Passport.

Persons travelling outside of their Place Of Residence, especially those travelling in some foreign countries, often encounter special difficulties when faced with a medical Emergency.

Arrangements have been made with Worldwide Assistance Services, Inc. (WA) to alleviate some of these difficulties.

Sun Life recommends that you bring your **Medi-Passport** card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.

At the time of an Emergency, the covered person or someone with the covered person must contact WA. If contact with WA cannot be made before services are provided, contact with WA 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.

Advances and guarantees - If necessary, in order to provide needed services of the type described in paragraphs 2, 3, 4, 5, 6, 7, 8 and 9, WA will, upon request, advance funds or give guarantees of payment. Advances will not be made for requests for less than \$200. Requests in excess of \$200 will be made in full up to \$10,000. The maximum amount advanced will not exceed \$10,000 per person per trip unless such limitation will compromise the medical care of the Insured Person.

Services provided

1. **24-Hour Access:** Multilingual telephonic access where available and telex or telegraphic access to the fully staffed emergency centre, 24 hours a day, for an Insured Person or a provider of medical services to an Insured Person, to confirm coverage and obtain access to other covered services.
2. **On the Spot Medical Assistance:** As soon as WA is notified that an Insured Person has been in a medical Emergency, its multilingual staff will, whenever appropriate or necessary in the judgement of WA or a physician designated by WA, attempt to establish communication with local attending medical personnel and facilities in order to obtain an understanding of the Insured Person's situation, to monitor his condition and to guarantee and, if necessary, advance to the provider of the medical services payment of the medical expenses incurred by the Insured Person.

WA will, upon request, attempt to locate a physician, pharmacist or other health care provider or facility for the Insured Person.

3. **Medical Evacuation:** Pursuant to the recommendation, and in the sole discretion of a physician designated by WA in consultation with a local attending physician, that it is necessary for an Insured Person to be transported under medical supervision to a different hospital or treatment facility or to be repatriated to his Place Of Residence, WA will arrange, guarantee and, if necessary, advance to the provider of the service payment for transportation to such different hospital, treatment facility, or Place Of Residence.

Decisions made by physicians employed by, under contract to and/or designated by WA as to the medical need for evacuation and/or repatriation services, are medical decisions based on medical factors and shall be conclusive in determining the need for such services. Decisions as to the means and/or timing of any transportation, the medical equipment and supplies and medical personnel to be used in connection therewith and the selection of the Insured Person's final destination are also medical decisions to be made by Sun Life or WA, based on available medical evidence, and shall be conclusive in determining the need for such transportation.

4. **Return of Stranded Insured Person:** If an Insured Person
 - A. is a child under the age of 16 or mentally or physically handicapped and is left unattended while travelling with another Insured Person who, during the trip, had to be hospitalized outside of his Place Of Residence, or
 - B. has lost the use of his ticket as the result of the delay

(a) caused by a medical Emergency requiring his confinement or repatriation, or the confinement or repatriation of his Spouse or Child, who is travelling with him and who is also an Insured Person, to a hospital or treatment facility, or

(b) caused by the need to repatriate the remains of another Insured Person,

WA will, upon request, arrange and pay for the transportation of the Insured Person back to his Place Of Residence.

The maximum amount payable will be the cost of transportation, net of the redeemable portion, if any, of the original ticket.

5. **Return of Children:** If an Insured Person entitled to the benefits of paragraph 4 is a child under the age of 16 or mentally or physically handicapped for whom the presence of an attendant during travel is essential, WA will make arrangements for a qualified attendant, approved by a member of the Immediate Family, to accompany the child.

Immediate Family in this paragraph and in paragraph 6 means the Insured Person's spouse, parent, child, brother or sister.

6. **Visit of a Family Member:** If an Insured Person, who is travelling alone or travelling only with a child who

A. is himself an Insured Person, and

B. is either under the age of 16 or mentally or physically handicapped,

is hospitalized for more than seven consecutive days outside his Place Of Residence, WA will, upon request, arrange and pay for the visit of one family member of the Insured Person's Immediate Family from such family member's home to the place where the Insured Person is hospitalized.

Maximum amount payable:

- up to a maximum of \$150 per day for up to seven days for meals and accommodations at a commercial establishment, and
- one round-trip economy fare.

7. **Special Service:** In case of the death of an Insured Person while travelling outside of his Place Of Residence, WA will arrange and pay for all necessary government authorization and for the return of the remains to his Place Of Residence in a container appropriate for transportation.

Maximum amount payable - up to \$5,000 per return.

8. Meals and Accommodations at a commercial establishment for:
- A. an Insured Person who, once arrived at a destination outside of his Place Of Residence, remains behind when the trip is delayed or interrupted due to a medical Emergency or death of another member of the travelling party who is also an Insured person.

Maximum amount payable - \$150 per day for a maximum of seven days, and

- B. an Insured Person, for a period of convalescence following a medical Emergency, if the attending physician and WA determine that hospitalization is no longer required and the Insured Person is not yet able to travel after his release from the hospital.

Maximum amount payable - \$150 per day for a maximum of five days.

9. **Vehicle Return:** WA will, upon request, arrange and pay for the return of an Insured Person's vehicle either private or rental, to the Insured Person's Place Of Residence or to the nearest appropriate vehicle rental agency when the Insured Person is unable to do so due to a medical Emergency or death.

Maximum amount payable - up to \$500 per return.

10. **Telephone Interpretation Services:** In a medical Emergency, WA will provide translation services in all major languages for an Insured Person who needs help in communicating.
11. **Transmission and Retention of Urgent Messages:** Upon request and when notified that an Insured Person has been in a medical Emergency, WA will transmit an urgent message for an Insured Person to his home, business or other location. WA will also retain messages to be picked up by the Insured Person or his family in its offices for up to 15 days.
12. **Lost Luggage, Lost Documents:** If an Insured Person who is outside of his Place Of Residence notifies WA that his luggage or travelling documents have been lost or stolen, WA will endeavour to assist the Insured Person by contacting the appropriate authorities and providing directions for replacement.

BENEFITS PAYABLE BY SUN LIFE

Subject to the clause "Reimbursement to Sun Life by the Insured Person", amounts advanced by WA to the Insured Person or paid by WA to providers of services and which are:

1. eligible expenses under other provisions of this policy; or
2. amounts advanced or paid by WA in connection with paragraphs 2, 3, 4, 5, 6, 7, 8 and 9,

are the responsibility of Sun Life and need not be reimbursed to Sun Life by the Insured Person.

REIMBURSEMENT TO SUN LIFE BY THE INSURED PERSON

It is a condition of the granting of this benefit by Sun Life and, by availing himself of any of the services provided by this benefit, the Insured Person undertakes that he shall reimburse Sun Life as outlined below for any amount which WA has advanced to or in respect of an Insured Person or which has been paid by WA to a provider of the services to an Insured Person and which is not otherwise the responsibility of Sun Life under this policy:

1. Amounts advanced or paid in connection with services to be reimbursed to the Insured Person by the Medicare Plan of his Province of residence

The Insured Person or his estate shall either reimburse them to Sun Life directly or make arrangements so that the Medicare authorities reimburse them to Sun Life.
2. Amounts advanced or paid in connection with eligible expenses covered under other provisions of this policy

The Insured Person shall reimburse Sun Life for any of those amounts to the extent that

- A. they exceed the maximums provided by this policy;
 - B. they are used to satisfy a deductible or co-insurance under the Medicare Supplement provision (coinsurance being the percentage of eligible expenses which the Insured Person pays after the deductible has been satisfied); or
 - C. they are expenses which are not Sun Life's responsibility by reason of an exclusion or a limitation in this policy.
3. Amounts advanced or paid in connection with paragraphs 4, 5, 6, 7, 8 and 9

The Insured Person or his estate shall reimburse Sun Life for any amount so advanced or paid in excess of the limits mentioned in these paragraphs.

4. Other amounts advanced or paid by WA or guarantees given by WA for the benefit of an Insured Person

The Insured Person or his estate shall reimburse Sun Life for any amount advanced or paid by WA, or for any amount paid by Sun Life as a result of guarantees of payment given by WA, where such amount was expended in respect of services not covered by this policy.

If the advance or payment was made by WA in respect of a dependent of an employee, the employee is personally liable, jointly and severally with the dependent, for the reimbursement of any amount under this clause.

All reimbursements must be effected within six months of the return of the Insured Person to his Place Of Residence, with interest at a rate established by Sun Life from time to time, from the time Sun Life bills the Insured Person for such advance or payment to the eventual date of payment.

REIMBURSEMENT BY SUN LIFE TO THE INSURED PERSON

If, after having confirmed coverage with WA under paragraph 1 and after receiving confirmation from WA that a medical Emergency exists, an Insured Person incurs expenses of the type for which he could have obtained advances under the terms of the present benefit and pays for such expenses himself, Sun Life shall reimburse him for such expenses as they are the responsibility of Sun Life under the clause "Benefits payable by Sun Life".

Proof of claim must be received by Sun Life within 30 days of the return of the Insured Person to his Place Of Residence.

COORDINATION OF COVERAGE

If a person is insured under this benefit for services which are subject to this provision and is also insured under any other plan arranged through any credit card, financial institution or travel wholesaler, which provides similar benefits which are also subject to this provision, Sun Life will coordinate its benefit payment with such other plans.

The plan first contacted by the Insured Person, or to whom a claim is first submitted, is considered the first carrier. Any other plan that shares a liability is considered the other carrier. The first carrier will be responsible for management of the case and for claims assessment and reserves the right to recover expenses in excess of its share from the other carrier(s) and from provincial health plans. Mutually covered expenses will be shared equally among all carriers and deductibles will be consistently applied to the largest common expense item.

LIMITATIONS

WA's services currently are not available in the following countries: Afghanistan, Bhutan, Bosnia, Haiti, Rwanda, Somalia and Yemen (list subject to change). In addition, WA reserves the right without prior notice to suspend, curtail or limit its services in any area in the event of rebellion, riot, military up-rising, war, labour disturbance and strike, nuclear accident, act of God, or refusal of authorities in the country of assistance to permit WA to fully provide service to the best of its ability during any such occurrence.

No services shall be provided in the Insured Person's Place Of Residence.

MEDICAL DECISIONS

Decisions by a physician, pharmacist, or other health care provider as to the medical need for providing any of the services covered by this clause are medical decisions based on medical factors and, as such, shall be conclusive in determining the need for these services.

DISCLAIMER OF LIABILITY

It is a condition of the granting of the present benefit by Sun Life and, by availing himself of any of the services provided by this benefit, the Insured Person recognizes that, in all cases,

1. any physician, pharmacist, or other health care provider or facility providing direct services to the Insured Person shall be considered an independent contractor acting in a medical capacity on behalf of the Insured Person only;
2. neither Sun Life nor WA assume any responsibility for any medical advice given by any physician, pharmacist, or other health care provider or facility, and neither Sun Life nor WA shall be liable for their negligence or other wrongful acts or omissions while providing direct service pursuant to this benefit; and

3. the Insured Person shall not have any recourse against WA nor Sun Life by reason of WA suggesting, or contracting with, a physician, pharmacist, or other health care provider or facility.

DEFINITION OF EMERGENCY

Acute Illness or accidental injury that requires immediate, medically necessary treatment prescribed by a Doctor.

DEFINITION OF INSURED PERSON

A person is an Insured Person under this benefit only if he is also an insured person under the Medicare Supplement Benefit Provision of this policy.

DEFINITION OF PLACE OF RESIDENCE

The Province in Canada where an Insured Person is a permanent resident.

Dental Insurance

If, while insured, you or your Dependents incur any of the Eligible Expenses listed below, Sun Life will pay a benefit, subject to Limitations and Exclusions. The amount payable is determined by using the Insured Percentages shown for the types of procedures, and based on the lower of (i) the actual charge and (ii) the amount in the Suggested Fee Guide. A benefit is not payable after the Maximum Benefit has been paid.

The Benefit Year, the Suggested Fee Guide, the Insured Percentages and the Maximum Benefit can be determined from the Benefit Details.

Eligible Expenses

TYPE A – PREVENTIVE, DIAGNOSTIC, EMERGENCY OR PALLIATIVE SERVICES

Charges for

1. oral examinations
 - A. complete examination – limited to one during any 24 month period.
 - B. recall examinations – must be separated by an interval of at least 5 months and limited to two per Benefit Year.
 - C. emergency or specific examinations.
2. radiographs and radiographic interpretations
 - A. complete series of radiographs or panoramic x-rays – limited to one during any 24 month period.
 - B. sets of bitewing radiographs – must be separated by an interval of at least 5 months and limited to two per Benefit Year.
 - C. radiographs to diagnose a symptom or examine progress of a particular course of treatment.
3. required consultations with another Dentist.
4. polishing (cleaning of teeth) and topical fluoride applications – must be separated by an interval of at least 5 months and limited to two such treatments per Benefit Year.
5. emergency or palliative services.

6. diagnostic tests and laboratory examinations.
7. removal of impacted teeth and related anaesthesia.
8. provision of space maintainers for missing primary teeth.
9. pit and fissure sealants.
10. oral hygiene instruction – must be separated by an interval of at least 5 months and limited to two sessions per Benefit Year.

TYPE B – RESTORATIVE AND SURGICAL PROCEDURES

Charges for

1. fillings – amalgam, composite, acrylic or equivalent.
2. removal of teeth – except removal of impacted teeth (a Type A Eligible Expense).
3. prefabricated metal restorations and repairs to prefabricated metal restorations – other than in conjunction with the placement of permanent crowns.
4. endodontics – root canal therapy and root canal fillings, treatment of disease of the pulp tissue.
5. periodontics – treatment of disease of the gum and other supporting tissues of the teeth.
6. surgery and related anaesthesia other than:
 - A. removal of impacted teeth (a Type A Eligible Expense),
 - B. implants and transplants, or
 - C. repositioning of the jaw.
7. repair of bridges or dentures.
8. rebase or reline of an existing partial or complete denture.
9. professional visits.

TYPE D – ORTHODONTIC PROCEDURES (applies to those persons indicated in the Benefit Details)

Charges for

1. interceptive, interventive or preventive orthodontic services, other than space maintainers (a Type A Eligible Expense).
2. comprehensive orthodontic treatment, utilizing removable or fixed appliance, or combinations of both (includes diagnostic procedures, formal treatment and retention).

Pre-Determination

If the expected cost exceeds the Pre-Determination Limit shown in the Benefit Details send the Dentist's proposed treatment plan (completed dental claim form) to Sun Life before treatment commences. Sun Life will advise you the amount payable for the treatment taking into account possible alternate procedures or course of treatment based on accepted dental practice. This will make you aware of the amounts payable before the dental work is done.

Co-ordination of Benefits

If you or any of your Dependents are insured for similar benefits under any other group plan, payments under this plan may be limited, but only to the extent necessary to limit reimbursement from all group plans to 100% of actual expenses.

Benefit after Provision Termination

If a procedure is performed after this provision terminates, a benefit is payable as if this provision had not terminated for the repair of damage to natural teeth resulting from an accidental blow to the mouth, provided:

1. the accident occurred while the person was insured and this provision was in force, and
2. the procedure is performed within 12 months after the date of the accident.

Limitations

Payment is not made for

1. dental services payable in whole or in part under any legislation, except to the extent that it permits excess payment.
2. any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.

3. services or supplies for which no charge would have been made in the absence of this coverage.

Exclusions

A benefit is not paid for

1. dental services provided primarily for improving appearance.
2. charges for dentures lost, misplaced or stolen.
3. charges for appointments not kept or completion of claim forms.
4. expenses related to services or supplies of the type normally intended for sport or home use, such as but not limited to, mouthguards.
5. charges for services or supplies rendered for full mouth reconstructions, vertical dimension corrections, or for the purpose of splinting.
6. charges for dental services due to or resulting from:
 - A. the hostile action of any armed forces, insurrection or participation in a riot or civil commotion,
 - B. any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation, or
 - C. commission or attempted commission of a criminal offence by the insured person.

Making a Claim

If you or any of your Dependents incur Eligible Expenses while insured, a claim must be made not later than 90 days after the earliest of the following dates:

1. the end of the calendar year during which the expenses were incurred,
2. the termination of your insurance, and
3. the termination of this provision.

You incur an Eligible Expense on the date

1. a single appointment procedure is performed.
2. a multiple appointment (other than orthodontic) procedure is completed.

