Sun Life Financial

your group benefits

York University

York University Faculty Association (YUFA)
Retirees and Survivors on or after May 1, 2016
Health and Dental Plans

Contract Number 14098
Effective May 1, 2026

Table of Contents

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

Extended Health Care (Medicare Supplement) **7**
General description of the coverage 7
Deductible 7
Prescription drugs 7
Hospital expenses in your province 9
Expenses out of your province/out of Canada 11
Medical services and equipment 14
Paramedical services 19
Vision care 19
What is not covered 20
Integration with government programs 21
When and how to make a claim 21

Dental Care **22**
General description of the coverage 22
Deductible 23
Benefit year maximum 23
Predetermination 23
Preventive dental procedures 23
Basic dental procedures 25
Major dental procedures 27
What is not covered 28
When and how to make a claim 29

Health Spending Account....31
General description of the coverage....31
How your Health Spending Account works....31
Plan credits....32
Surviving dependent coverage....32
Eligible expenses....32
Other coverage....38
When and how to make a claim....38

Lumino Health Virtual Care Employee Assistance Program, powered by Dialogue....39

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.

Legal actions

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

Coordination of benefits

If you or your dependents are covered for 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.

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.

Reference to Doctor may also include a nurse practitioner – If the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, Sun Life will reimburse those eligible services or supplies prescribed or ordered by a nurse practitioner the same way as if they were prescribed or ordered by a doctor. For drugs, refer to *Other health professionals allowed to prescribe drugs.*

An expense must be claimed 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

There is no deductible for this coverage.

Prescription drugs

We will cover 90% 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 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.

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.

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.

Emergency services outside Canada

We will pay 100% of the cost of covered emergency services outside Canada.

We will only cover emergency services obtained within 60 days of the date you leave Canada. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

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 (ETA) provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Sun Life's ETA provider prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

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

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

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

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

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster.

Sun Life and Sun Life's ETA provider coordinate the whole process with most provincial plans and all insurers, and send you a payment for the eligible expenses. Sun Life's ETA provider will ask you to sign a form authorizing them to act on your behalf.

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

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 Sun Life's ETA provider, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- 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 $1,000,000 per person or, if lower, any other applicable lifetime maximum.

Medical services and equipment

We will cover 100% of the costs 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 cannot 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.
- 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 electrospinal stimulators for the correction of scoliosis.
- prone standers.
- braces and cervical collars. Braces are wearable, orthopaedic appliances that rely on a rigid material such as metal or hard plastic to hold part of the body in the correct position.
- casts, splints (including shoes attached to a splint) or trusses. Intra-oral splints are excluded.
- canes , crutches, walkers and parapodiums.
- pressure garments for burn patients.
- dressing/bandages.

- breast prostheses required as a result of surgery. If internal breast prostheses are provided, we will cover the costs based on coverage for external breast prostheses.
- artificial limbs, including repairs.
- artificial eyes, including rebuilding and polishing of artificial eye.
- myoelectric appliances, up to a maximum of $10,000 per prostheses.
- shoulder harnesses.
- cleft palate obturators.
- stump socks, up to a maximum of 6 pairs per person in a benefit year.
- elastic support stockings 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 prescribed by an ear, nose and throat specialist, up to a maximum of $1,100 per person per benefit year. Repairs are included in this maximum.
- 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.

- 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. Continuous glucose sensors and continuous glucose transmitters are not included in the maximum.
- insulin pumps, limited to 1 pump over a period of 5 benefits years.
- extremity pump for lympedoma or severe postphlebitic syndrome.
- catheter and catheterization supplies.
- speech aids such as Bliss boards and communication aids, when no alternative method of communication is possible.
- obus forme back support.
- food substitutes that must be administered through a tube feeding process. Tube feeding pumps and pump sets are also covered.

Paramedical services

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

- licensed psychologists.
- licensed massage therapists, up to a maximum of $1,500 per person in a benefit year.
- 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.

Vision care

We will cover the cost of contact lenses, eyeglasses, laser eye correction surgery and the services of an ophthalmologist or licensed optometrist. Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

We will cover 100% of these costs up to a combined maximum of $600 per person over 2 benefit years.

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

We will not pay benefits when the claim is for an illness resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.

- participation in a criminal offence.

Integration with government programs

This plan will integrate with benefits payable or available under the government-sponsored plan or program (the *government program*).

The covered expense under this plan is that portion of the expense that is not payable or available under the government program, regardless of:

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

When and how to make a claim

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

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

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

Dental Care

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 $3,300 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 100% 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 Implants, including surgery charges. Charges for a replacement implant is not considered an eligible expense during the 5 year period following the insertion of a previous implant.

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).
- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

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

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

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

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

Health Spending Account

General description of the coverage

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

Your Health Spending Account coverage pays for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependent are also covered. Coverage applies only to expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependent is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

The benefit year is from January 1 to December 31.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses, up to the balance of your account. If a claim exceeds your account balance, the claim will be paid up to the amount in your account and returned to you. You should submit it again once you have the additional credits required. Expenses incurred in one benefit year for which credits have been allocated can be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible

expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Plan credits

$675 on the commencement of each benefit year.

If your coverage starts after the commencement of the benefit year, your plan credits are adjusted by the employer for that benefit year. If you need additional information, please contact your employer.

Surviving dependent coverage

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

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

Eligible expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act (Canada) **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act (Canada) is changed, this plan is automatically updated to reflect the changes.

Drugs

- drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses

- eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances

- deductible and coinsurance amounts under medical or dental plans.

Licensed practitioners (fee for services)

- acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapeutists.

Dental care

- preventative, diagnostic, restorative, orthodontic and therapeutic care.

Attendant care

- remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.

- remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.

Facilities

- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.

- payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an

"appropriately qualified person" must certify the individual and his or her special requirements.

Hospitals

- payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.
- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of $1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.

- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.

- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.

- costs of medical services and supplies outside of the province of residence.
- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
  - equivalent medical services are not available locally.
  - the route is reasonably direct.
  - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

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

When and how to make a claim

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

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

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

Lumino Health Virtual Care Employee Assistance Program, powered by Dialogue

General description of the program

The services listed below are offered through Dialogue. These services are not insured or administered by Sun Life.

In this section, *you* means the employee and all dependents as defined under the group plan.

Your Employee Assistance Program (EAP) is a confidential and voluntary support service that can help you with:

- Family and Relationships
- Mental Health
- Child and Elder Care
- Work and Career
- Manager consultation
- Legal services*
- Financial services**
- Assistance during time of crisis
- Internet-based cognitive behavioural therapy (iCBT)

*Does not include legal services related to immigration law or employment law, or legal advice or representation
**Does not include financial product sales or direct investment advice, accounting and/or tax preparation, legal or notarial questions, or insurance (limited)

When you access Lumino Health Virtual Care EAP, your needs will be assessed and a personal support plan will be designed for you.

Your EAP includes:

- Up to four sessions per issue with subject matter experts (via chat or video consult)
- Unlimited access to online tools and resources available through Lumino Health Virtual Care, powered by Dialogue

Lumino Health Virtual Care EAP offers a variety of services including access to mental health professionals. To learn more about the services provided by Dialogue, or to use these services, please visit https://luminovc.dialogue.co/.

Confidential service

Your EAP is completely confidential. Your employer will not be advised that you have used the service unless you choose to tell them.

Cost

There is no cost to use EAP and no claims to submit.

Liability and responsibility of Sun Life

Sun Life will not be held liable for any acts or omissions of any person or organization providing services directly or indirectly in connection with Dialogue.

Respecting your privacy

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

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).