Your Benefits

EMPLOYEE BENEFITS

for

Support Staff Employees of the Ontario Colleges of Applied Arts and Technology

Contract Number 50834 and 50090
Effective January 1, 2015

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Section 1 - General Information

About this booklet

This booklet has been developed for you and your family by individuals currently on the Support Staff Joint Insurance Committee (JIC) who represent the Ontario Public Service Employees Union (OPSEU), the Colleges of Applied Arts and Technology (CAAT), the College Employer Council (Council), and representatives from the Insurance Company, Sun Life.

The information contained in this booklet will not in any way diminish current benefit levels in effect as of the date of printing.

The information in this booklet is important to you and should be kept in a safe place. It describes all group insurance benefits available to you (both mandatory and voluntary), explains your entitlements and various administrative issues relating to the Group Insurance Benefit Program. For confirmation of the specific benefit coverage you have elected, please refer to your copy of your Group Insurance Benefits Positive Enrolment Form or contact your College's Benefits Plan Administrator.

It is important to note that this booklet is only a summary of your group contract. It is not a legal document. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority and the Insurance Company will follow the group contract when making a decision to pay a claim.

Benefits described in the booklet are applicable only if you and your Dependent(s) are insured according to the records maintained for the group contract. If you have any questions about the information in this employee benefits booklet, or if you need additional information about your group benefits, please contact your College's Benefits Administrator or Local Union Representative.

About the Group Insurance Benefits Program

The Group Insurance Benefit Program and the cost-sharing arrangements provided to the CAAT Support Staff Employee Group are a result of negotiations and are set out in the Support Staff Collective Agreement.

Section 2 - Roles and Responsibilities

College Employer Council
(Contract Holder)

The College Employer Council (Council) is the Contract Holder on behalf of the Colleges, and is responsible to ensure that the terms of the group contract are adhered to by the Insurance Company and the Colleges.

About the Joint Insurance Committee (JIC)

The Support Staff JIC consisting of representatives of OPSEU, CAAT and the Council has been established under the Terms of Reference found in Appendix A of the Support Staff Collective Agreement. The committee meets on a regular basis to discuss Group Insurance Benefits matters. The duties of the Committee include the review of contentious claims and recommendations thereon, when such claim problems have not been resolved through the existing administrative procedures.

Colleges
(Administrators)

The Colleges of Applied Arts and Technology have the responsibility to maintain all records regarding an employee's coverage, ensure the rules contained in the group contracts are adhered to and communicate the provisions of the group contract to employees.

Each College has a designated individual(s) in the Human Resources Division and/or Payroll Services who is responsible for the Group Insurance Benefit Program.

OPSEU
(the employee's representative)

OPSEU is responsible to:

- represent employees covered by the Support Staff Collective Agreement on matters relating to Group Insurance Benefits.
- educate members about benefits.
- communicate with the Contract Holder (the Council) on matters relating to the Group Insurance Benefits.
- participate with the Council in discussions about Group Insurance Benefit issues through the Joint Insurance Committee (JIC) in accordance with the Terms of Reference of the Support Staff JIC as outlined in the Collective Agreement.

Sun Life
(Insurance Company)

The Insurance Company is responsible to adjudicate and pay claims in accordance with the provisions in the group contract between Sun Life and the Council on behalf of the Colleges.

Employee

You are responsible to:

- know what your benefits are.
- follow the claims submission processes, providing the information requested.
- be an educated consumer.
- keep Human Resources Department at your College informed about changes that may affect the status of your benefits.

Section 3 – Definitions

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.

Actively At Work

You are considered to be 'actively at work' if you are performing all the usual and customary duties of the job with the College for the scheduled number of hours. This includes non-working days and paid vacation if you were 'actively at work' on the last scheduled working day.

Appropriate Treatment

Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Base Salary

Base salary is your regular salary from the college not including any bonus, overtime or incentive pay.

Benefit Year

September 1 to August 31. (Applicable to Vision and Hearing Care only).

Calendar Year

January 1 to December 31. (Applicable to Extended Health Care and Dental Care).

Dentist

A person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practising of dentistry, and who is operating within the scope of the issued licence. The definition usually includes licensed dental hygienists, dental assistants or denturists, etc.

Dependent(s)

Your eligible Dependent(s) are your spouse/partner, your children and your spouse/partner's children (other than foster children) who are residents of Canada and the United States.

Spouse/Partner

- your spouse or partner by virtue of a legal marriage, or
- your partner of either sex in a relationship of some permanence, if you are the natural or adoptive parents of a child, as defined in the Family Law Act, 1990 (Ontario), or
- your partner who cohabits with you in a conjugal or homosexual relationship continuously for a period of not less than 1 year, or
- your partner who is publicly maintained and represented as your spouse continuously for a period of not less than 1 year.

Note: For group insurance purposes your spouse/partner will cease to meet the definition of a person eligible to be qualified as your dependent upon the earlier of:

- the date you have entered into a “Separation Agreement” with your spouse/partner; or
- having lived separate and apart from your spouse/partner for not less than 12 months.

Only one person at a time can be covered as your Spouse/Partner.

Children under age 21

- unmarried and under age 21, who live with you in a normal parent/child relationship.
- unmarried child under age 21 for whom you are appointed legal guardian and lives with you in a normal parent/child relationship.

Children age 21 and over but under age 25 (Student)

An unmarried child who is attending college or university as a full-time student is also considered an eligible Dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

Disabled Children

If a child is disabled by a mental or physical infirmity before the limiting age, coverage will be continued as long as:

- the child is incapable of financial self-support because of physical or mental disability, and
- the child depends on you for financial support and maintenance and is not married nor in any other formal union recognized by law.

In order to ensure there is no disruption in benefit coverage you must provide proof to your Benefits Administrator within 31 days of the date the child attains the limiting age. The completed "**Disabled Child Coverage**" form must be forwarded to Sun Life to ensure continuation of coverage.

In order for a child to qualify to be covered past the "limiting age" as a result of a disability, from an age perspective, they must be under 21 at the time they become disabled or, if they are 21 or older, they must be under age 25 AND a full-time student at the time they became disabled.

Doctor

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

Eligibility Requirements

Conditions that must be satisfied in order to participate in the Plan, and obtain a benefit.

Employee

You are employed by the College on a full-time basis as a Support Staff employee in accordance with the terms of the Support Staff Collective Agreement.

Hospital

Hospital is defined as a legally operated institution which is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and provides such facilities under the supervision of a staff of doctors with a 24 hour a day nursing service by registered nurses.

Notwithstanding the above, hospital shall mean a legally operated institution in which a person establishes, to the satisfaction of Sun Life, that such confinement was for active treatment that would normally be found in a general hospital.

In no event will that part of an institution which operates as a home for the aged, rest home, nursing home, chronic care facility or a place for the care and treatment of drug addicts or alcoholics be considered a hospital for the purpose of this contract.

Facilities and services that are not covered

The Plan does not cover the facility nor the services provided in 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.

Palliative Care

Services for palliative care provided in a hospital, as defined under Regulation 964 under the Public Hospitals Act, R.S.O. 1990, c.P-40 are covered by the Extended Health Care Plan.

Services for palliative care provided at Casey House or any other hospice which is approved for hospital purposes pursuant to an Order-in-Council under the Public Hospitals Act are covered by the Extended Health Care Plan.

Illness

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

Incurred Expense

An expense is incurred on the date the service is received or the supplies are purchased or rented.

Reasonable and Customary Expenses

Standard medically approved treatments and procedures which are normally applied in the treatment of a particular illness or condition and are provided at costs equivalent to the normal charges for such treatment in the location where such treatment is provided.

Survivor(s)

Your Eligible Dependent(s) if you die while employed by the College provided you were participating in the group insurance benefits at the time of your death. Refer to Section 9 for further details.

Section 4 - Categories of Benefits

Mandatory Benefits

You must participate in the following benefits:

- Basic Life Insurance
- Accidental Death and Dismemberment Insurance (AD&D)
- Long Term Disability
- Extended Health Care (includes Vision and Hearing Care)
- Dental Care

Premiums

Benefits	College Pays	You Pay
Basic Life Insurance	100%	0%
A.D. & D Insurance	100%	0%
Long Term Disability	75%	25%
Extended Health Care	100%	0%
• *Vision Care*	75%	25%
• *Hearing Care*	75%	25%
Dental Care	100%	0%

Optional Benefits

You may elect to participate in the following benefits:

- Supplemental Life Insurance
- Employee Optional Life Insurance
- Dependent Life Insurance
- Spousal Supplemental Life Insurance
- Critical Illness

Premiums

Benefits	College Pays	You Pay
Supplemental Life Insurance	60%	40%
Employee Optional Life	0%	100%

Dependent Life Insurance	0%	100%
Spousal Supplemental Life Insurance	0%	100%
Critical Illness	0%	100%

Life Insurance Premium Paid by the Employer

The premiums the College pays towards your Basic Life and Supplemental Life Insurance are taxable income to you. This amount forms part of your income and it will be reflected on your Income Tax Statement from the College each year.

Premium Deductions

In addition to the cost of the benefits, if you are a resident of Ontario, Quebec or a resident of Manitoba, provincial retail sales tax is applied to the actual premium and must be paid by you and the College. The College Benefits Plan Administrator will provide the premium deduction information to you at the time of enrolment.

Section 5 - When Coverage Begins

New Employee

The waiting period for a new employee under your group contract is indicated on the following chart:

BENEFIT	WAITING PERIOD
Basic Life Insurance Accidental Death & Dismemberment Insurance Supplemental Life Insurance Employee Optional Insurance Dependent Life Insurance Spousal Supplemental Life Insurance Extended Health Care (includes Vision and Hearing Care)	Completion of one month of continuous full-time employment.
Dental Care	Completion of the probationary period.
Long Term Disability	On the first of the month co-incident with or following completion of three months of continuous full-time employment.
Critical Illness Insurance	Completion of one month of continuous full-time employment.

Coverage begins

Your coverage begins the first day following the completion of the waiting periods provided you are ‘actively at work full-time’ on the date your coverage becomes effective. In the event you are absent on that date, you will qualify on the day you return to ‘active work full-time’. For Critical Illness coverage, refer to Section 16.

If for any reason, you stop being actively at work, you should contact the Benefits Administrator at your College to determine the status of

your benefits.

In the event benefit improvements for Life Insurance and Long Term Disability are negotiated, you must be actively at work full-time on the date the changes are effective in order to qualify for the improvements. If you are absent on that date, you will qualify on the date you return to active work full-time (See Section 3 “Definitions”).

Dependent(s)

Coverage for your Dependents begins on the latest of:

- the date you become eligible, if they are your Dependents on that date.
- the date they first become your Dependents after the effective date of your coverage, if your request for coverage is received by the College within 31 days, or
- for Life Insurance, on the date of approval by Sun Life if your request for coverage is received later than 31 days after they first become your Dependents.
- for Extended Health and Dental Care, on the date of the request.
- for a Dependent, other than a newborn child, who is hospitalized, coverage will begin when the Dependent is discharged from hospital.

Section 6 - Enrolment

Enrolment Form

At the time you commence employment, the Benefits Administrator at your College will arrange to meet with you to review your Group Insurance Benefit entitlements.

You will be required to complete and sign a detailed enrolment form which collects the necessary information about yourself and your Dependent(s) (if applicable) in order for the College to administer the Group Insurance Benefit Program, and for Sun Life to adjudicate and process claims. It is important that you read this form, fully answer the questions, sign and date the form where required and return it to your Benefits Administrator no later than 31 days after you become eligible for the coverage.

This enrolment form also contains information relating to the completion date of your waiting period and the effective date of your mandatory and optional benefits.

You will be enrolled in the mandatory and optional benefits following completion of the appropriate waiting periods.

Your Certificate Number

Your College will assign you a certificate number that will be used to set up your benefit information and which you can use to generate an identification card on line in the event you need to produce proof that you have benefit coverage. This certificate number will be a unique number and will contain a code to identify your employee group, your College and your file. This is necessary in order for Sun Life to process your claims and for you to access your claims information from Sun Life.

Confidentiality

Your privacy is respected and the information collected is held by the Colleges and Sun Life in the strictest confidence. At Sun Life Financial, access to your personal information is restricted to the persons outlined in the *Respecting Your Privacy* clause at the end of this booklet.

Updating your Records

To ensure that your benefit coverage is kept up-to-date, it is important that you report any of the following changes to your Benefits Administrator at the College:

- change of name.
- change of beneficiary.
- addition of a spouse/partner and/or dependent child.
- change in marital status.
- death of a spouse/partner and/or dependent child.

Section 7 - Changing Benefit Coverage

Changes affecting your coverage

Changes in employment and personal status may affect your benefit coverage. It is important for you to contact your Benefits Administrator to discuss your benefit coverage prior to the effective date of an employment status change or within 31 days following a personal status change.

Benefit coverage during leaves of absence, illness, etc.

There is provision in your group contract for you to continue benefit coverage when you are not actively at work, provided certain criteria are met. This means that if you are absent from work on an employer-approved personal leave of absence with pay, personal leave of absence without pay, maternity/parental leave, professional development leave, illness or disability, benefits can be continued.

If you are absent on a leave of absence without pay the maximum period of time you may continue to participate in the benefit plans is 24 consecutive months.

Personal status changes and Extended Health and Dental Care benefits

You may change your Extended Health, Vision, Hearing, and Dental Care coverage from single to family or vice-versa under the following special circumstances:

- if there is a change in your marital status.
- if you gain or lose a dependent.

To change your coverage, you must notify the Human Resources Department within 31 days of when the change takes place.

To determine when a spouse/partner will cease to qualify as a Dependent please see Section 3, Definitions "Spouse/Partner.

To add or increase Life Insurance coverage

In the event you wish to add, or change the amount of your Optional Life Insurance, or obtain Life Insurance for a newly acquired Dependent, you may do so without a medical examination or other evidence of insurability provided you are actively at work and you apply for the Life Insurance coverage for you or your Dependent within 31 days of the following:

- the date of your marital status change
- the date you acquire a Dependent or an additional Dependent.

Proof of good health

To increase your Life Insurance or obtain Dependent Life Insurance at any time other than referenced above you will be required to submit proof of good health via a Health Questionnaire Form obtained from the College's Benefits Administrator.

If coverage previously declined

In the event you have previously applied for and been declined for additional Life Insurance coverage, the 31 days provision referenced above is not applicable. You may continue to submit proof of good health to Sun Life annually. However, depending on your individual situation, you may never be eligible for this coverage.

Effective date of coverage

- if proof of good health is required, the change cannot take effect until Sun Life approves your application.
- if you are not actively working full-time when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active full-time work.
- if a Dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the Dependent's coverage cannot take effect before the Dependent is discharged from hospital.

Section 8 - Termination of Coverage

When coverage ends
For Active Employees

As an employee, your coverage will end on the earliest of the following dates:

- the end of the month in which your employment terminates.
- the end of the month in which you retire.
- the date the group contract is no longer in force.
- the end of the period for which the premium is paid for your insurance.
- the date you die.
- for Long Term Disability (LTD), the date you retire, the date you attain age 64 and 6 months, whichever is earlier.
- for Supplemental Life, Employee Optional Life, Dependent Life and Spousal Supplemental Life the end of the month in which you attain age 65.
- for Critical Illness, see Section 16

When your group Life Insurance coverage ends or reduces refer to Section 15 for details about converting it to an individual Life Insurance policy.

For Dependent(s) of Active Employees

Your Dependent's coverage will end on the earliest of the following dates:

- the date your coverage ends.
- the date the group contract is no longer in force.
- the end of the period for which premiums have been paid for the Dependent coverage.
- the date the Dependent no longer meets the definition of an eligible Dependent.
- the date you die. Survivor Benefits may be elected by your Dependents for Extended Health Care (including Vision and Hearing Care) and Dental Care coverage (see Section 9).

Coverage after Retirement

If you retire, you may continue certain benefits. You must enrol in the CAAT Retiree benefit plan within 31 days of the date of your retirement. Please request information from your Benefits Plan Administrator or refer to the Council's website at www.theCouncil.on.ca for an explanation of eligibility requirements and the benefits available to retiring employees.

Section 9 - Survivor Benefits

Survivor Benefits
For Eligible Dependent(s) of Active Employees

Provided you are participating in the Dependent coverage for Extended Health Care (including Vision and Hearing Care) and Dental Care Plans when you die, coverage for your eligible dependents will continue until the earliest of the following dates:

- the last day of the sixth month following the month in which you die unless the survivor elects to continue the coverage.
- the end of the period for which premiums have been paid.
- the date the benefit provision under which the Dependent is covered terminates.
- the date the group contract terminates.
- the date the survivor would no longer be considered the employee's dependent if the employee were still alive.
- the date the survivor cancels the coverage.
- the date you would have reached age 65.
- the date the survivor dies.

Who pays the premium?

The College pays the full premium for the first six months for the Extended Health (including Vision and Hearing Care) and Dental Care benefits. Thereafter, the survivor may elect to continue these benefits and is required to pay the College quarterly, in advance, the full cost of the Plans.

If the eligible survivor is in receipt of a lifetime monthly survivor pension from the CAAT Pension Plan, the survivor may then elect to participate in retirement benefits provided such election is made within 31 days from the date you (deceased employee) would have reached age 65 and the eligible survivor continues to be eligible for benefits under OHIP or another Canadian medicare plan equivalent to OHIP from another province or territory.

The eligible survivor will keep the College informed of any change in address or other information as the College or the insurer may require. The eligible survivor will be requested to provide the following information in order to ensure claims are paid appropriately and delays in processing the payments are avoided.

- their date of birth.
- their Social Insurance Number.
- proof that they are in receipt of a lifetime monthly survivor pension from the CAAT Pension Plan.

Section 10 - Extended Health Care
(Medicare Supplement)

General description of the coverage

The **Extended Health Care Plan** pays for eligible services or supplies that are medically necessary for the treatment of an illness and supplements your provincial hospital and medical insurance plans (e.g. OHIP). *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. Any amount payable under the Extended Health Care Plan is subject to the coinsurance and the list of eligible expenses. The Ontario Health Insurance Act prohibits duplication of coverage of the provincial medical and hospital plans. To qualify for this coverage under this plan, you must be a Canadian resident and entitled to coverage under OHIP or another Medicare plan equivalent to OHIP from another Canadian province, territory or Canadian federal government plan.

In some instances, where permitted by law, expenses covered under this Extended Health Care plan are integrated with certain provincial medicare programs such as the Ontario Assistive Devices Program (ADP) and the Ontario Drug Benefit Plan (ODB). Please refer to the end of this section for a brief description of these programs.

Who is covered?

All full-time Support Staff employees who have completed the waiting period are covered by the Extended Health Care Plan which includes semi-private hospital accommodation.

Waiting Period

One month of continuous full-time employment. The coverage begins on the day following the completion of your waiting period provided you are actively at work on that day. Otherwise the insurance becomes effective when you return to work.

Amount of Coverage

- 100% of the difference between the cost of a ward and a semi-private hospital room rate in Canada.
- 100% of eligible expenses for Vision Care to a maximum of $400 in any Benefit Year for persons under 18 years of age, and each two Benefit Years for persons 18 years of age and older (see Vision Care for further information).
- 100% of eligible expenses for Hearing Care to a maximum of $3,000 in each 3 Benefit Year period (see Hearing Care for further information).

Note: Since there are specific plan years for Vision and Hearing Care, the details of which are referred to later in this booklet, it is recommended that prior to making a purchase for vision and/or hearing care, you should contact Sun Life to ensure that you are eligible to claim the purchase.

85% of eligible expenses for:

- services, while not confined to a Hospital, of private duty registered nurses if medically necessary to an annual maximum of $25,000 per insured individual.
- eligible prescription drugs.
- eligible medical services.
- dental services required as the result of an accident.
- paramedical services.

Payment after coverage ends

If your Extended Health Care Insurance terminates while you are totally disabled, treatment of the disabling condition will be covered, while your total disability continues, as if your insurance under the Plan had continued in force for an additional 6 months.

This benefit also applies to pregnancy provided your pregnancy commenced prior to the termination of your employment with your College.

A similar extension of benefits is available for a Dependent who is totally disabled when his or her insurance terminates.

Coverage under more than one plan

If you are covered for Extended Health Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. Please refer to the 'Submission of Claim' section of this booklet for instructions.

Hospital expenses in Canada
Reimbursement Amount

The Plan will cover 100% of the following costs:

- the difference between the cost of a ward and semi-private hospital accommodation when confined to a hospital in Canada (includes all provinces and territories in Canada).
- hospital out-patient services provided in Canada, except for any services explicitly excluded under this benefit.

Prescription Drugs and Vaccines

Please note that doctors occasionally prescribe drugs which may be readily available over the counter or vaccines that do not require a prescription by law. These drugs and/or vaccines are not covered by the Plan, except as otherwise indicated below under eligible expenses. Ask your pharmacist about the category of the drug you have been prescribed when you get your prescription filled.

For further information or to confirm coverage you may contact Sun Life's call centre at 1-800-361-6212 or 416-753-4300 or by e-mail at askus@sunlife.ca (must have your contract and certificate number available).

Reimbursement Amount

The Plan will cover 85% of the cost of the following drugs and supplies that are prescribed by a licensed doctor or dentist and are obtained from a licensed pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a written prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.

Drug substitution limit

Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

The following items are covered on a reimbursement basis, they are not available with the drug card:

- vaccines that legally require a prescription. However, the Plan also covers hepatitis B and influenza vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections if medically necessary.

Payments for any single purchase are limited to the cost of a supply that can reasonably be used in a 34 day period or, in the case of maintenance drugs, up to 100 days as ordered by a doctor.

The Plan will not pay for the following, even when prescribed:

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments to encourage weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- products to help a person quit smoking.
- over-the-counter drugs, except as otherwise provided under the list of eligible expenses above.
- 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.
- drugs and supplies that do not qualify as eligible medical expenses under the *Income Tax Act* (Canada).

Other health professionals allowed to prescribe drugs

The Plan reimburses 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.

Medical services
Reimbursement Amount

The Extended Health Care Plan will cover 85% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed dentist do not require a doctor’s order).

Private Duty Nursing

Pre-determination of eligibility is required for this benefit for you or your dependent. Obtain and submit the “In Home Nursing Care Questionnaire" form, to be completed by the attending physician.
Expenses for private duty nursing services, outside of a hospital, are eligible if the care is:

- carried out by a registered graduate nurse (R.N.), certified nursing assistant (C.N.A.), registered nursing assistant (R.N.A.), or licensed practical nurse (L.P.N.). Service provider must be licensed, certified or registered in the province where you live

and who does not normally live with you.

- medically necessary and prescribed by the licensed attending physician, and
- the type of medical care that can only be performed by a qualified R.N., C.N.A., R.N.A., or L.P.N.
- services must be for nursing care and not for custodial care.

Ambulance

OHIP covers the cost of licensed ambulance services, where medically necessary, for local transportation of the person to and from the nearest hospital qualified to provide the required care. You are responsible to pay a co-payment for these services. The Extended Health Care plan will reimburse you for 85% of the co-payment amount.

In the event that an unexpected condition occurs (emergency situation) such as illness, disease or injury which requires immediate assistance, the use of a licensed air ambulance for transportation of the person to the nearest hospital qualified to render the emergency medical services, the expense is covered by OHIP in the province of Ontario. The Extended Health Care plan will pay a maximum of what would have been payable for a local land ambulance trip.

Dental Services as the result of an accident

Dental services for the repair or alleviation of damages to natural teeth sustained in an accident occurring while you or your Dependent(s) are insured under this provision. The services include braces and splints. These services must be received within 6 months after the accident. You will not be covered for more than the fee stated in the Dental Association Fee Guide for a general practitioner in the Province of Ontario. The fee guide must be the current guide at the time that treatment is received.

Note*:* It will be necessary for you to provide a separate detailed account of the cause of the injury to Sun Life along with the Extended Health claim form.

Medical Supplies and Equipment

The Plan covers medically necessary equipment rented that meets the person's basic medical needs. It is important to note that where the purchase of durable equipment is less expensive than rental, it will be given consideration by Sun Life.

When suitable alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the person's basic medical needs. For example, manual wheelchairs are normally considered sufficient to meet basic medical needs, except if the person's medical condition warrants the use of an electric wheelchair.

- casts, splints, trusses, braces and crutches.
- breast prostheses and surgical bras, required as a result of surgery, up to a maximum of $600 per person in any Calendar Year.
- artificial limbs and eyes (excluding myoelectric appliances), including repairs and replacements when medically necessary. Coverage may be co-ordinated with the Assistive Devices Program administered by the Province. Further information is provided at the end of this section.
- oxygen and its administration. Coverage may be co-ordinated with the Assistive Devices Program administered by the Province. Further information is provided at the end of this section.
- wigs required as a result of illness or following chemotherapy.
- elastic support stockings, including pressure gradient hose, up to a combined maximum of 4 pairs per person in a calendar year.

Orthopaedic Shoes

Orthopaedic shoes, up to a maximum of 3 pairs for persons under 8 years of age, 2 pairs for persons 8 years of age or over but under 18 years of age and one pair for persons 18 years of age and over, in a Calendar Year.

To be eligible for coverage your shoes (or orthotics) must be prescribed by a specific qualified specialist as a medically necessary treatment for a foot condition and dispensed by a foot care specialist.

- Prescribed by:
  - Doctor (M.D.)
  - Podiatrist (D.P.M.)
  - Chiropodist (D.Ch. or D Pod M)
- Dispensed by:
  - Podiatrist (D.P.M.)
  - Chiropodist (D.Ch. or D Pod M)
  - Pedorthist (C. Ped. (c) or C Ped. MC)
  - Orthotist (C.O. (c) or CPO (c)

The purchase of custom-made orthotics that may be less costly may be covered in place of orthopaedic shoes, when professionally prescribed and subject to the same limitations and frequency as orthopaedic shoes. You are eligible for either orthopaedic shoes or orthotics, not both, in each calendar year.

Prior to making your purchase it is recommended that you obtain confirmation that the claim will be eligible for payment. This can be done by forwarding the information given to you by the service provider directly to the claims department at Sun Life.

Paramedical services

The Plan will cover 85% of the costs, up to a combined maximum of $1,500 per person in a Calendar Year for all eligible expenses listed below; this includes the difference between what OHIP allows for podiatrists and your actual charge.

Paramedical services must be deemed by the profession's licensing/regulatory board to be within the scope of that profession. A service deemed to not be within the scope of the profession will not be covered.

Note: the paramedical service provider must be licensed to practice in the province in which the services are rendered.

Doctor's order not required:
Services of licensed osteopath (includes osteopathic practitioners)*, chiropractor*, chiropodist*, podiatrist*, naturopath, massage therapist, speech therapist, physiotherapist, audiologist, optometrist/ophthalmologist, occupational therapist, psychologist and acupuncturist.
*includes one x-ray examination per specialty each Calendar Year

What is not covered

The Plan 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 payable in whole or in part under the provisions of the Medicare Plan in your province of residence.
- hospital services or supplies to the extent they are covered under the Hospital Plan which are paid for in whole or in part under the provisions of the Medicare Plan, whether or not you or your Dependent(s) are enrolled under the provincial plan.
- services or supplies for which the person is eligible for payment under any group medical, surgical or hospital plan.
- any services or supplies over the reasonable and customary charges in the locality where they are provided.
- 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).

The Plan 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 a civil commotion.
- any work for which you were compensated that was not done for the College who is providing this Plan.
- the Plan will also not pay benefits when compensation is available under the Workplace Safety and Insurance Act, Criminal Injuries Compensation Act or similar legislation.

Coordination 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.

Vision Care

To correct vision impairment, the Plan will cover the cost of contact lenses, laser eye correction surgery or eyeglasses-lenses and frames including tinting, sunglasses, safety glasses and their replacement, as long as they are prescribed in writing by an ophthalmologist or a licensed optometrist and are obtained from an ophthalmologist, licensed optometrist or qualified optician.

Laser eye surgery, if performed by an ophthalmologist may be co-ordinated with available coverage under paramedical services.

The Plan will cover 100% of these costs up to a maximum of $400 in any Benefit Year for persons under 18 years of age, with the Benefit Year commencing September 1 and a two Benefit Years period for persons 18 years of age and older, with the benefit period commencing September 1 of even numbered years. Maximums will renew annually for persons under 18 years of age and every 2 years for all other persons.

The Plan will not pay for glasses of any kind purchased over the counter or examinations by eye care professionals.

PVS - Preferred Vision Services Inc.

Sun Life offers a Preferred Vision Care program. You can achieve a savings of up to 20% on all frames, prescription lenses and lens add-ons at registered PVS locations. You will be required to present your PVS card at the time of purchase. PVS cards can be obtained from your College Benefits Administrator.

Hearing Care

To correct a hearing impairment, the Plan will cover the cost of hearing aids, including maintenance and repairs, prescribed in writing by an Ear, Nose and Throat (E.N.T.) specialist, Otolaryngologist, Medical Doctor (M.D.) or an Audiologist, up to a maximum of $3,000 per person for the current benefit period ending August 31, 2015. The maximum is then $3,000 every 3 consecutive years thereafter.

In addition to the more usual hearing aid devices, coverage will also include expenses for aids to hearing if prescribed by a medical doctor. These will include:
1. a device that produces extra-loud audible signals such as a bell, horn, or buzzer;
2. a device to permit the volume adjustment of telephone equipment above normal levels;
3. a bone-conduction telephone receiver; and
4. the batteries that are required for that purpose, and repairs;
5. teletypewriter or similar device, including a telephone ringing indicator, that enables an individual to make and receive telephone calls;
6. a device to decode special television signals to permit the script of a program to be visually displayed; and
7. a visual or vibratory signalling device, including a visual fire alarm indicator, for an individual with a hearing impairment.

These expenses will be subject to the $3,000 maximum per insured person and time frame limitation as noted above.

Coverage may be co-ordinated with the Assistive Devices Program administered by the Province.

Coverage under more than one plan

If you are covered for Vision and Hearing Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. Please refer to the 'Submission of Claims' section of this booklet for instructions.

Your coordination with Government Plans

Details of current coverage under the government medicare plans can be found on the website of the Ontario Ministry of Health and Long Term Care at www.health.gov.on.ca. The following provides a brief description of some of the services that are integrated with

your Extended Health Care coverage.

Assistive Devices Program (ADP): This program is operated by the Ontario Ministry of Health. It assists Ontario residents covered by the Ontario Health Insurance Plan who have a long term physical disability (ask your doctor for details). The program covers a number of items such as hearing aids, orthotic devices, ostomy supplies, prosthetic devices (such as breast prostheses), insulin pump and supplies, etc. As coverage can change from time to time, please refer to the Ontario Ministry of Health and Long Term Care website for details.

Home Oxygen Program (HOP): This program covers oxygen and oxygen delivery equipment such as concentrators, liquid systems, masks, tubing, etc. Contact the Operational Support Branch of the Ontario Ministry of Health and Long Term Care for details.

Ontario Drug Benefit Plan (ODB): You and/or your spouse are eligible for the prescription drug benefit on the first day of the month following the attainment of age 65.

Moving Out of Province

If you move from one province to another province or territory it is important that you register for the provincial medicare plan in your new province as soon as possible (90 days or whatever is indicated by the province you are moving to) so that you do not jeopardize your Group Insurance benefits coverage. You are not eligible for Group Insurance coverage under this plan if you do not have provincial medicare coverage.

Section 11 - Expenses Out-of-Province and Your Extended Health Care Plan

Expenses out of your province

The Plan will cover emergency services while you are outside the province where you live. The Plan also covers referred services.

For both emergency services and referred services, the Plan 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

The Plan will pay 100% of the cost of covered emergency services.

The Plan will only cover emergency services obtained within 60 days of the date you leave the province where you live. 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 provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative

procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

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

Emergency services excluded from coverage

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

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

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. The Plan will pay 80% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $2,000,000 per person or, if lower, any other applicable lifetime maximum.

Emergency Travel Assistance

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

General description of the coverage

If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (*Europ Assistance*) can help. (Information regarding Europ Assist can be found on the Sun Life Financial Plan Member Services website at www.mysunlife.ca)

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

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

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

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

confirm your coverage and receive assistance.

Getting help

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

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

Europ Assistance may arrange for:

On the spot medical assistance

Europ Assistance will provide referrals to physicians, pharmacists and medical facilities.

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

Europ Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel.

Europ Assistance will transmit an urgent message from you to your home, business or other location. Europ Assistance will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

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

supplies and personnel are needed.

Meals and accommodations expenses

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

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

Travel expenses home if stranded

Europ Assistance will arrange and, if necessary, advance funds for transportation to the province where you live:

- for you, if due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated; or
- for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

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

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

Travel expenses of family members

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

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

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

of 7 days.

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Limits on advances

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

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

Reimbursement of expenses

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

To receive reimbursement, you must provide Sun Life with proof of the

expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Europ Assistance:

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.
- amounts paid for services or supplies not covered by this plan.
- amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

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

Limits on Emergency Travel Assistance coverage

There are countries where Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.

Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
- the refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Europ Assistance

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

Section 12 - Dental Care

General description of the coverage

Amount of Coverage

- 100% of eligible expenses for preventative dental procedures.
- 100% of eligible expenses for restorative and surgical procedures.
- 100% of eligible expenses for prosthodontic procedures.
- 50% of eligible expenses for inlays, onlays, crowns, repairs of crowns, repair of bridges, construction and insertion of bridges.
- 50% of eligible expenses for orthodontic procedures.

What are the maximums?

	Insured Percentage	Maximum
Types A, B and C Eligible Expenses: Basic Services, including dentures	100%	$2,500 Types A, B and C combined (per calendar year)
Type E Eligible Expenses: Crowns & Bridges	50%	$2,500 (per calendar year)
Type D Eligible Expenses: Orthodontic	50%	$2,500 (Lifetime)

What fees are covered?

The fees stated in the Ontario Dental Association Fee Guide for **general practitioners** which was current one year prior to the date the eligible expenses were incurred, regardless of where the treatment is received.

Temporary Dental Services

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.

Preventive Dental Procedures
(Type A – 100%)

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.

Oral examinations

- initial examination limited to one during any 24 month period.
- 1 recall examination every 5 months, up to a maximum of 2 examinations per calendar year.
- emergency or specific examinations.
- preventive recall packages.

X-rays

- 1 complete series of x-rays or 1 panorex limited to one during any 24 month period.
- 1 set of bitewing x-rays every 6 months, up to a maximum of 2 sets per calendar year.
- X-rays to diagnose a symptom or examine progress of a particular course of treatment.

Other services

- Required consultations with another dentist, excluding those for orthodontic purposes.
- Required consultations between patient and dentist, excluding those for orthodontic purposes.
- Fillings - amalgam, silicate, composite, acrylic or equivalent.
- Polishing (cleaning) and topical fluoride treatment, once every 6 months, up to a maximum of 2 per calendar year.
- Protective athletic appliance (mouthguards).
- Scaling.
- Other preventive services.
- Diagnostic tests and laboratory examinations, excluding x-rays, study models or similar records prepared for orthodontic procedures.
- Provision of space maintainers for missing primary teeth.

Restorative Dental and Surgical Procedures
(Type B – 100%)

Your dental benefits include procedures used to treat basic dental problems and include:

- Required consultation between your dentist and another dentist.
- Retentive pins.
- Prefabricated, full coverage restorations.
- Caries, trauma and pain control.
- Professional visits.

Extraction of teeth
- Removal of teeth.

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

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

Oral surgery
- Surgery and related anaesthesia, other than implants and transplants, and repositioning of the jaw.
- Therapeutic intra-muscular or intravenous drug injection.
- Adjunctive general services.

Denture Procedures
(Type C – 100%)

Your dental benefits include removable dental prosthesis to resolve dental problems and include:
- Complete maxillary and/or mandibular dentures - once every 3 years per arch.
- Removable partial dentures - once every 3 years.
- Denture adjustments.
- Repair of dentures.
- Rebase or reline of an existing partial or complete denture.
- Customary commercial laboratory fees associated with the above.

Crown and Bridges
(Type E – 50%)

Your dental benefits include permanent dental prosthesis to resolve dental problems and include:
- Bridges.
- Repairs to bridges.
- Inlays.
- Onlays.
- Pins in inlays, onlays and crowns.
- Post and core.
- Crowns and repairs to crowns.

[Special Provisions for Implants: If a claim is made for an implant, **the implant itself and related surgery are not an eligible expense** under the Plan; however, the plan may reimburse you for up to the level of service that is applicable under the alternate benefit clause.
The Plan will pay based on the least expensive alternate service as follows:

- If a crown is "the least expensive alternate service", the Plan will reimburse the allowable fee for a standard crown.
- If a denture is "the least expensive alternate service", the Plan will reimburse up to the allowable fee for a denture, either partial or full.
- If a bridge is "the least expensive alternate service", the Plan will reimburse up to the allowable fee for a bridge.

Please refer to the section "What is not covered" for more information about the alternate benefit clause. A pre-determination will identify what portion of the cost, if any, will be reimbursed.

Replacement of dentures and bridges

Construction and insertion of bridges or standard dentures - once every 3 years. Charges for a replacement bridge or replacement standard dentures are not considered an eligible expense during the 3 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.

Orthodontic Procedures
(Type D – 50%)

Your dental benefits include procedures used to treat misaligned or crooked teeth subject to a lifetime maximum of $2,500 per person and include:

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- Required consultations between patient and dentist
- Diagnostic services - orthodontic cast.
- Observation and adjustment.
- Repairs.
- Alterations.
- Re-cementations.
- Separation.

- Fixed - bilateral/unilateral or removable orthodontic appliances.
- Appliances to control oral habits.
- Myofunctional therapy.
- Retention appliances.

Predetermination
Recommended where expenses will exceed $300

To ensure that you and your Dentist are aware of the expenses that will be paid by the Plan, it is strongly recommended that you send a predetermination form to Sun Life, before the work is done, for any major treatment or any procedure.

How do I file a predetermination?

This can be done by your Dentist directly via electronic submission or if necessary:

- you can obtain a claim form from your Human Resources Department.
- ask your Dentist to complete the appropriate sections of the form.
- you complete your sections of the form, sign it and forward it to Sun Life.

Sun Life will advise you, taking into account possible alternate procedures or course of treatment based on accepted dental practice, how much of the planned treatment is covered by the Plan and how much of the cost you will be responsible for before the work is done.

Laboratory Fees

- Certain procedures will usually involve the cost of a commercial laboratory and when appropriate, a reasonable and customary laboratory fee will be reimbursed subject to the same overall maximums. Please note that predetermination cannot take laboratory fees into account but the appropriate payment will be included at the time of claim.

The only circumstance in which benefits will be considered for an ineligible procedure is when your Dentist advises, in writing, that it is both less expensive and better for you than an eligible procedure which could be done.

Coverage under more than one plan

If you are covered for Dental Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. These standards determine where you should send a claim first. Please refer to the 'Submissions of Claims' section of this booklet for instructions.

What is not covered

The Plan 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.
- services or supplies that are not usually provided to treat a dental problem, including experimental treatments.
- 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.
- 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.
- expenses related to services or supplies of the type normally intended for home or sport use except mouthguards.

Dental expenses resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- any cause for which compensation is available under the Workplace Safety and Insurance Act, Criminal Injuries Compensation Act or similar legislation.

Payments after coverage ends

If your coverage terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if:

- the accident occurred while the person was still covered, and
- the procedure is performed within 6 months after the date of the accident.

Expenses Outside of Province/Canada

Expenses incurred for emergency dental care outside of Province/Canada will qualify as eligible expenses to the extent that they represent the usual, customary and reasonable charges for dental care in the locality where the dental care is performed, provided an expense for such dental care would qualify as an eligible expense in the Province of Ontario.

For expenses incurred for dental care performed outside Canada on other than an emergency basis, the benefit provided under this contract will be the usual, customary and reasonable charges for dental care in the locality where the dental care is performed but not exceeding the level of eligible expenses for the Province of Ontario.

Section 13 - Short Term Disability Plan (STD)

General description of the coverage

The Colleges have full legal, financial and administrative responsibility for this benefit. Questions or inquiries in regard to this benefit must be directed to your College Benefits Administrator.

If you are hired as a full-time employee on or after September 1, 2005, you are eligible for benefits under the Short Term Disability Plan (STD) from the first day of work with the College.

The STD will provide benefits for the first 130 working days you are absent due to an illness or disability in a "plan year".

The first ten (10) working days in the "plan year" will be paid at 100% of your regular base earnings with the remainder of the 130 working days paid at 75% of your regular base earnings. Employees in their first year of employment will have their ten (10) days entitlement pro-rated in proportion to the amount of the year that they work.

The ‘plan year” begins on September 1 of each year.

If you recover from one absence due to illness or disability but are again absent due to illness or disability during the plan year, STD benefits will recommence from the point at which they were discontinued.

Full STD benefits are normally reinstated on the first working day of each new plan year, provided you are actively at work full-time on that day and you are not absent again for the same or related cause for which benefits were paid under the previous year's entitlement. If you are absent on that day, the following procedures will apply:

(1) (a) Full STD benefits will be reinstated following one month of return to your regular hours of work provided you are not again absent due to the same illness or disability.

(b) If you are absent due to the same illness or disability, you may only use the balance of benefits from the previous plan year.

(2) If you return to your regular hours of work and are absent due to illness or disability during the first 30 calendar days following your return due to a different illness or disability, full benefits will be reinstated at the end of that period. However, this absence may be covered by any balance of credits from the previous plan year, as indicated below.

Short Term Disability payments will be reduced by other disability payments being received such as from the Canada Pension Plan or the Workplace Safety Insurance Board.

ACCUMULATION OF UNUSED STD DAYS

Any of the ten (10) days paid at 100% that are unused at the end of the plan year will be carried forward to the next plan year to be used in future years. Unused days can only be carried forward to a maximum accumulation of 120 working days and may only be used for the STD benefit.

This extends the number of days you receive 100% of your regular base earnings from ten (10) working days by the number of unused STD days that have been "banked" to a maximum of 130 working days. Once these days have been used, the remainder of the 130 working days allowed in a plan year will be paid at 75% of your regular base earnings.

Upon retirement, layoff or termination of employment, unused days banked in your name shall be cancelled and shall be of no effect.

After you have used the 130 working days of STD benefits, which are available in one plan year (together with any extensions available, if any, pursuant to the "Accumulative Sick Leave Credits" specified below), benefits may be provided under the Long Term Disability Insurance Plan, underwritten by Sun Life Assurance Company of Canada.

The full cost of all Short Term Disability benefits is paid by the College.

ACCUMULATIVE SICK LEAVE CREDITS
PRIOR TO SEPTEMBER 1, 1973
AND NOT APPLICABLE TO SUPPORT STAFF
HIRED AFTER SEPTEMBER 1, 1973

Your accumulative sick leave credits prior to September 1, 1973 will

be maintained. However, there will be no further accruals or transfer-in of accumulative sick leave after September 1, 1973. Existing accruals will be frozen and used to supplement the STD Plan. One-quarter of a credit from the accrual will be used to supplement each day under the STD plan from 75% to 100% of earnings.

If, at the end of the 130 working days STD period there are any unused credits in the sick leave accrual, you will continue to draw sick leave on a per day basis at 100% of earnings level until these credits are exhausted. The commencement of Long Term Disability benefits, will be deferred until all sick leave entitlements have been paid.

Any vesting provisions that may have been established or agreed to by the College applicable to past sick leave credits recognized at the commencement of employment will continue to apply to any such unused credits remaining in the accrual, in accordance with the conditions and provisions established by the College at the commencement of employment. The vesting provisions established by the College applicable to current sick leave credits accrued while employed by the College will apply to any such unused credit remaining in the accrual. The dollar amount of any cash benefit to be paid in accordance with the relevant conditions established by the College will be based on salary at December 31, 1977 or in the case of some former public servants retiring prior to December 31, 1977, the date of retirement. The gratuity is calculated in accordance with the following formula:

$$\frac{\text{No. of days of credit}}{2} \times \frac{\text{Salary at December 31, 1977}}{261}$$

The cash benefit payable following an employee's death will be determined in the same manner as for a retirement.

Vesting provisions distinguish between sick leave credits earned before and after joining the College, and therefore the accrual will be determined on a first-in first-out basis. (Viz: The transferred credits are used before College credits are drawn upon).

Since these benefits relate to the old cumulative Sick Leave Plan, they will be paid by the College.

Section 14 - Long Term Disability Income Plan (LTD)

General description of the coverage

As a full-time Support employee you have Long-Term Disability coverage, which provides a benefit to you if you become 'totally disabled' for an amount equal to 66 2/3% of your regular earnings. Employees receiving disability payments under the Plan up to September 1, 1974, shall continue to receive benefits under the original Plan providing for benefits of sixty per cent (60%) of regular earnings so long as such disability continues and subject to the provisions of the original Plan.

If you become totally disabled while insured, Sun Life will pay, subject to Limitations and Exclusions, a Long Term Disability Benefit for each month you remain totally disabled after completion of the elimination period until you cease to be totally disabled or the last day of the month in which you attain age 65. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you are under the regular care of a doctor.

If the group contract is cancelled for any reason while you are receiving the Long Term Disability Benefit, payments will continue in accordance with the terms of the group contract.

What is meant by Totally Disabled

You are considered totally disabled if, because of bodily injury, sickness or disease:

- you can perform none of the duties relating to your regular work during the elimination period and subsequently for a period up to but not exceeding 24 months, and
- afterwards, you will be considered totally disabled if you are wholly and continuously prevented from engaging in any occupation or employment for wage or profit for which you are reasonably qualified by education, training or experience.

LTD Benefits and Taxation

Because the College pays 75% of the premium for this coverage, the benefits are taxable to you on receipt.

Elimination period

To be eligible for Long Term Disability Benefits, you must have completed the waiting period for benefit coverage and have been 'totally disabled' for the elimination period specified in your plan.

The elimination period is the amount of time during which you must have been unable to work due to your incapacity. This is normally the period of time when you would have received Short Term Disability or Cumulative Sick Leave Credit payments from the College.

When disability payments begin

Your Long Term Disability payments begin after you have completed the elimination period. The elimination period is the period commencing when you became totally disabled and ending on the later of:

- the completion of 130 working days (including statutory and college holidays) of absence due to illness in the past 12 months, or
- the expiration of Short Term Disability and Sick Leave Credits.

Payment of Long Term Disability benefits is not automatic. You must submit an LTD claim. In addition, you may also be eligible for Canada Pension Plan disability benefits and you are advised to contact the nearest Income Security Program office, Human Resources Development Canada (HRDC).

Eligibility for coverage

The waiting period is the period from the date of your full-time employment up to and including the last day of the third month of employment. Coverage begins on the day following the completion of the waiting period, provided you are actively at work on that day. Otherwise the insurance becomes effective when you return to work.

Coverage ends

Your coverage will end on the earliest of the following dates:

- the end of the month in which your employment terminates.
- the date you attain age 64 and 6 months.
- the end of the period for which the premium is paid for your insurance.
- the date your group contract is no longer in force.
- the date you die.

If you become totally disabled during an approved leave and have elected to continue your coverage during the leave period you will be eligible for benefit payments following your scheduled return to full-time work with your College. You must have been totally disabled for the elimination period and still be totally disabled on the date you are scheduled to return to full-time work with your College.

Ceasing to be actively at work does not, by itself, mean that you are totally disabled.

Proof of disability

Once the claim is approved, proof of your continuing disability will be

required from time to time depending on the medical evidence previously supplied by your doctor. Sun Life will send the appropriate documents when this information is required. The information requested will be used to determine your eligibility for the continuance of benefits and should be obtained and returned to Sun Life promptly (usually within 90 days) in order to avoid unnecessary interruptions or delays in your benefit payments.

In the event you no longer qualify as totally disabled, Sun Life will notify the College Benefits Administrator who is responsible for notifying you.

Medical examination

At the time your application is made for Long Term Disability benefits, medical information must be included. In the event that Sun Life is unable to render a decision on the claim based on the medical information provided, Sun Life may arrange for you to have an Independent Medical Examination (IME), at their expense.

Your cooperation in complying with Sun Life's request for an IME is very important because without the appropriate medical information Sun Life cannot approve the claim and benefits cannot be paid. An IME may also be required as proof of continuing disability.

How will my benefits be determined?

You will receive 66 2/3% of your Monthly Basic Earnings reduced by income from all other sources. All references to income in this disability provision are to the gross amounts before any deductions.

Monthly Basic Earnings

Monthly Basic Earnings are your regular earnings on the date of commencement of your elimination period.

Income Tax

The amount payable by Sun Life is subject to income tax.

Income from other sources

The following is 'Income From Other Sources' and will be subtracted from your LTD benefits:

- any continuation of salary from any employer in respect of employment prior to the date of commencement of the elimination period.
- any indemnity provided under any group insurance or group pre-payment plan.
- any amount of income provided under any retirement or pension plan of the Employer.
- any indemnity from any government operated or sponsored plan such as the Workplace Safety and Insurance Act, Canada Pension Plan and Quebec Pension Plan.
- any amount of income provided for you by reason of your disability under the legislation of any government or emanation thereof.

Please note:
you have a responsibility to ensure that you are receiving the proper benefit payment and that any offsets have been applied appropriately.

Not included in 'Income from Other Sources' are the following:

- any increase in income arising from the Quebec Pension Plan or the Canada Pension Plan because of an upward adjustment in the cost of living index (occurring either during the elimination period or while you are receiving a Monthly Indemnity Benefit).
- payments from Employment Insurance.
- payments from any Personal Life or Personal Disability policies.
- any amount of income provided for your Dependent(s) by reason of your disability under the legislation of any government or emanation thereof.

How will I receive my benefits?

The Long Term Disability Plan pays in advance. This means that your first benefit payment is due the first day after completion of the elimination period indicated on the application form submitted by the College. Subsequent payments are made on the first day of each month that you continue to qualify for benefits under the terms of the group contract.

You will be given the option of receiving your benefit payments by either cheque or electronic funds transfer directly into your bank account.

To ensure the accuracy of your disability benefit payments, you must advise your College Benefits Administrator immediately if:

- your medical condition changes.

- you begin to receive any other income (i.e., Canada Pension Disability Benefits, or you return to work, either full-time or part-time).

Your College Benefits Administrator is also responsible for informing Sun Life if you return to work.

Rehabilitation Program

The College has the obligation under the Human Rights Code to provide 'reasonable accommodation' for disabled employees. This may involve modifications to the job or your workplace. If there is potential for rehabilitation, you will be contacted by either your College Benefits Administrator or a Sun Life Counsellor.

Where there is the possibility of rehabilitation in order to return to work, you, your physician, the College or Sun Life may initiate the process.

Successful rehabilitation is a team effort and includes participation from the College, your Local Union representative, your attending doctor, Sun Life and you.

Rehabilitation Benefits

During your rehabilitation program, you may receive your Long Term Disability payments plus income from other sources, however, your Long Term Disability benefits will be offset by 50% of your rehabilitative earnings.

If, during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation, (less provincial and federal income taxes), your Long Term Disability payments will be reduced by the excess.

Recurrence of disability

If you have been receiving Long Term Disability payments and recover, but the same (or related) total disability recurs, you need not complete another elimination period unless you have been back at work on full-time for at least 6 months.

If you have a chronic disease or illness and suffer a relapse after the end of the period referred to above, Sun Life may, at its sole discretion, accept a subsequent claim as a continuation of the previous one at the same level of benefits and without applying a new elimination period.

Any such acceptance will be based on a consideration by Sun Life of the circumstances involved and will only be done if the group contract is in force at the time a request for such consideration is made. The benefits you receive will be based on the same benefit level as on the

original date of total disability.

How will my Life Insurance, Extended Health Care and Dental be affected?

Your Life Insurance, Extended Health Care and Dental Care remain in force during the time you receive Long Term Disability benefits provided that you were subscribing to such benefits on the date your Long Term Disability payments commenced.

Who pays the premiums?

The College shall pay one hundred per cent (100%) of the premiums payable for Extended Health Care, Vision Care, Hearing Care and Dental Care on your behalf if you are receiving Long Term Disability payments, provided you were enrolled in the benefits on the date your Long Term Disability payments began. No premiums are required for your Life Insurance coverage.

Waiver of LTD Premiums

No contributions for Long Term Disability will be required during any period you are receiving monthly benefits.

Your responsibilities

During your total disability, you are expected to make reasonable efforts to:

- keep the College and Sun Life informed about the status of your disability on a regular basis.
- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your College.
- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

When payments end

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

- the date you are no longer meet the definition of Totally Disabled.
- the last day of the month in which you reach age 65.
- the last day of the month in which you die.

Return to Work

Where you are eligible to receive Long Term Disability benefits and you are medically capable of returning to your former position within 24 months of being eligible to receive benefits, you shall be assigned, within a reasonable period of time, to:

- your former position
- a comparable classification in the same payband to your former

position provided you are capable of performing the job and such a position exists.

When you work less than the normal hours of work assigned to the position to which you have returned, your salary, Short Term Disability payments (if entitled) and vacation pay shall be pro-rated accordingly.

You shall not be required to work within 24 months of being eligible to receive Long Term Disability benefits unless you are medically capable of performing the duties of your former position.

Research has indicated that the most successful outcome of a return-to-work program is achieved when the rehabilitation program is engaged as soon as possible after commencement of disability.

If you have any questions pertaining to return to work, please feel free to contact your College Benefits Administrator, Local Union Representative or Sun Life.

Non-Payment of Long Term Disability
Limitations

In accordance with the group contract, Sun Life will not pay Long Term Disability benefits for any period that:

- you are not under the regular care of a doctor and receiving appropriate treatment.
- a period during which you engage in any employment or occupation for wage or profit (other than in a Rehabilitation Program) except as approved by Sun Life.
- you choose not to participating in a rehabilitation program approved by your Attending Doctor, the College and Sun Life.
- you are on a leave of absence except as stated under the Maternity/Parental leave of absence or except where specifically agreed to by Sun Life.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

When LTD benefits are not payable

In accordance with the group contract, Sun Life will not pay Long Term Disability benefits for any disability which results from:

Exclusions

Payment will not be made for a Total Disability which is due to or results from:

- participation in a riot, rebellion or, insurrection.
- war, declared or undeclared, or active duty in any armed service during a time of war.

- intentionally self-inflicted injuries, while sane or insane, by firearm or otherwise.
- commission or attempted commission of a criminal offence by you.

Recovering damages from a Third Party

This provision applies to every employee who claims Long Term Disability benefits under this group contract.

What are the Third Party Liability Provisions

If you have a cause of action against a Third Party for income lost as a result of your disability, the LTD benefit will be payable as specified in the group contract.

However, prior to the commencement of payments, you will be required to complete a form agreeing to reimburse Sun Life. The amount to be reimbursed will not exceed the amount of benefits paid by Sun Life.

If you recover money, you must pay Sun Life 75% of your net recovery or the total disability income benefits paid or payable to you under this Plan, whichever is less. Your net recovery does not include your legal costs. 75% of your net recovery must be held in trust for Sun Life.

Section 15 - Life Insurance Coverage

General description of the coverage

Basic Life Insurance is designed to ensure that your beneficiary does not face the additional burden of severe financial hardship in the event of your untimely death. This means that you are covered 24 hours per day while you remain an employee of the College and continue to meet the eligibility requirements for insurance under the group contract.

Basic Life Insurance ***(Mandatory)***

Amount of insurance is $25,000.

Accidental Death and Dismemberment Insurance ***(Mandatory)***

In addition to the Basic Life Insurance you have Accidental Death and Dismemberment (AD & D) coverage in the amount of $25,000. Details are provided in the following pages.

Supplemental Life Insurance ***(Optional)***

You may choose additional coverage in units of $10,000 to a maximum of $50,000.

Employee Optional Life Insurance ***(Optional)***

Provided you have chosen the maximum of $50,000 under the Supplementary Life Insurance benefit you may choose to be covered in units of $10,000 up to an additional $50,000 under the Employee Optional Life Insurance.

Overall maximum

The maximum amount of coverage for your basic life, supplementary life and employee optional life benefits combined is $125,000.

Unlike the AD&D coverage, there are no exclusions applicable to the Basic, Supplemental and Employee Optional Life Insurance.

Change without evidence of insurability

No medical examination or other evidence of insurability is required provided you are actively at work and you apply for the optional life insurance for you or your spouse within 31 days of the following:

- the date you completed your Waiting Period, or
- the date you acquire a Dependent or an additional Dependent, or
- the date your marital status changes.

What happens if I do not apply within 31 days or I wish to increase the amount of Life Insurance?

You will be required to furnish evidence of insurability to Sun Life. Such insurance coverage will take effect only upon the date your evidence of insurability is approved by Sun Life. It is important to note that it is possible that coverage could be declined. Serious consideration should be given before declining the life benefits at the time the benefits are first offered to you.

Coverage during total disability (*The contract holder has the sole legal and financial liability for the Coverage during total disability. Sun Life only acts as administrator on behalf of the contract holder***)**

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage for you and your dependents may continue without the payment of premiums as long as you are in receipt of Long Term Disability (LTD) benefits. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations. In addition, all continued coverage with Sun life terminates on the date the benefit under which the person is covered with Sun Life terminates.

Accidental Death and Dismemberment

General description of the coverage ***(Mandatory)***

Accidental Death and Dismemberment (AD & D) insurance is provided. This means that if, due to an accident occurring while covered, you die or suffer a dismemberment as listed in the table under *Table of Losses* you may be eligible for benefits. Any death benefit paid under this coverage is in addition to the Basic Life Insurance coverage.

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.

Your Accidental Death and Dismemberment Insurance

Amount of Insurance - $25,000.

100% of the insurance is payable in the event of accidental death. For other dismemberment situations the amount payable is $25,000 pro-rated in proportion to the percentages identified in the *Table of Losses Chart.*

What the Plan will pay

The Plan will pay for this benefit if you:

- accidentally drown.
- disappear in an accident while travelling. This only applies if the means of transportation disappears, sinks, is wrecked, forced to land or stranded and the body is not found within one year. There must be no evidence that you are still alive.
- are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within one year of that accident or exposure.

The amount that the Plan will pay is a percentage of the $25,000. The percentage depends on the loss suffered. The following table shows the percentages used to determine the payment. However, only the largest percentage is paid for injuries to the same limb resulting from the same accident, and the maximum payable due to any one accident is $25,000.

TABLE OF LOSSES CHART

Loss of life	100%
Loss of both hands	100%
Loss of both feet	100%
Loss of one hand	50%
Loss of one foot	50%
Loss of thumb and index finger on the same hand	33.33%
Loss of use of both arms	100%
Loss of use of one hand and one foot	100%
Loss of use of both legs	100%
Loss of use of one arm and one leg	100%
Loss of use of one arm	50%
Loss of use of one leg	50%
Loss of entire sight of one eye	50%
Loss of entire sight of both eyes	100%
Loss of sight of one eye and either one hand or one foot	100%

Accidental Loss

- Loss of a hand means that it was severed at or above the wrist.
- Loss of a foot means that it was severed at or above the ankle.
- Loss of a thumb and index finger means that they were severed at or above the first joint from the hand.
- Loss of sight must be total and permanent.

Loss of use of limb must be total, continuous for at least 12 months, and then must be determined to be permanent and irrecoverable before the benefit is payable.

What is not covered

The Plan will not pay AD & D benefits for losses that are the result of:

- intentionally self-inflicted injuries, by firearm or otherwise.
- taking any poison, drug or medicine, whether voluntarily or otherwise.
- inhaling gas, whether voluntarily or otherwise, other than as a result of performance by the employee of the regular duties of his employment.
- attempted suicide or suicide while sane or insane.
- flying in, descending from or being exposed to any hazard related to an aircraft while
  - receiving flying lessons.
  - performing any duties in connection with the aircraft (except when such duties are being performed as part of your occupation with the College).
  - being flown for a parachute jump.
  - member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your Accidental Death and Dismemberment insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Dependent Life Insurance

General description of the coverage ***(Optional)***

Dependent Life Insurance is term insurance which covers your spouse and dependent children while you remain an employee of the College and they continue to meet the eligibility requirements for the insurance.

Amount of Insurance

Spouse: $15,000 Each child: $3,000

The benefit is payable to you. Its purpose is to assist you and your family with the additional financial burden should your spouse or dependent children die.

Proof of good health

Required on all amount of coverage unless requested within 31 days of completing the waiting period or of acquiring a new dependent.

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your Dependent Life Insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Spousal Supplemental Life Insurance

General description of the coverage *(Optional)*

(Available only if you have elected Dependent Life Insurance)
To supplement your Dependent Life Insurance, additional life insurance is available to you. In the event of your spouse's death, the Plan will pay the insured amount to you.

Amount of Insurance

Multiples of $10,000 to up to a maximum of $60,000.

Proof of good health

Proof of good health is required for any increase in the amount of spouse insurance. The increase will take effect on the date Sun Life approves the proof of good health.

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your Spousal Supplemental Life Insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Appointing a Beneficiary

Beneficiary Appointments

You may name the beneficiary of your choice a person, persons or your estate. In the event of your death, benefits will be paid in the name of the last legally nominated beneficiary you have on file with Human Resources. In the absence of a beneficiary appointment, payment will be made to your estate.

Appointment of a Beneficiary in the Province of Ontario

Except as restricted by law, you may change your beneficiary at any time. In the Province of Ontario, the beneficiary is revocable by the insured. This means that you may change your beneficiary appointment at any time without the approval of your beneficiary.

Appointment of a Beneficiary in the Province of Quebec

The Province of Quebec requires that you indicate whether your beneficiary is revocable or irrevocable at the time you make your benefit election. If you have indicated the beneficiary is irrevocable at the time of enrolment, you may only change the beneficiary appointment with the written permission of the current beneficiary. The enrolment form provided by the College will contain this information.

Your beneficiary appointment can be a complex matter, and depending on your specific situation, you may wish to seek legal advice before making a nomination and/or changing an appointment. The necessary form is available from your Human Resources Department.

Life Insurance Conversion

Converting your Life Insurance

If your Life Insurance terminates or reduces as a result of changes in your coverage that are age-related or as a result of your termination of employment, you may apply to convert the group Life coverage, to an individual Life policy with Sun Life without providing proof of good health.

It is your responsibility to initiate an application to convert your Life Insurance with Sun Life. The College will issue a conversion form to you. This form will confirm details of your employment such as your start date with the College, the amount of insurance coverage in effect at the time of your separation from the College, the termination date of your insurance as well as providing a list of Sun Life numbers where you can call to get more information about your options on an individual policy. You have 31 days from the date your insurance is reduced or ceases to convert your Life Insurance to an individual Life policy with Sun Life.

If you die during the Conversion Period

If you die during this 31 day conversion period, the amount of Life Insurance coverage in effect at the time your coverage is reduced or ceases will be paid to your last named beneficiary as recorded on your file in the Human Resources Department as a death claim.

Converting your Dependent Life Insurance

When your Dependent Life insurance coverage ends, you may apply to convert your spouse's Life coverage to an individual Life policy with Sun Life without providing proof of good health.

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends due to the termination of your Life coverage, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good

health.

How long do I have to convert my spouse's life insurance?

You have 31 days from the date your spouse's Life insurance coverage ceases to convert to a private policy with Sun Life.

What happens if my spouse dies during the Conversion Period?

If your spouse dies during this 31 day conversion period, the amount of Life Insurance coverage in effect at the time the coverage is reduced or ceases will be paid to you.

Section 16 – Critical Illness Insurance

General description of coverage

Critical Illness insurance provides protection that Long Term Disability, Life Insurance, and Extended Health Care insurance coverages do not. Following the diagnosis of a critical illness and a prescribed survival period, this insurance pays a one-time, lump sum benefit (see Critical Illness brochure for additional information).

Eligibility

You are eligible to apply for coverage for yourself and/or your spouse provided you are a full-time Support Staff employee of the Colleges of Applies Arts and Technology.

To qualify you must:

- be between the ages of 18 and 65
- reside in Canada
- be actively at work
- provide proof of good health

A person who qualifies as both an employee and a spouse may be enrolled for coverage as an employee or a spouse, but not both.

Eligibility Date

Is the date you have completed the Waiting Period of one continuous month of full-time employment.

Coverage

Coverage is available to you and your spouse up to a maximum of $200,000 in units of $25,000.

Coverage Effective Date

- If you and your spouse apply on your Eligibility Date (or prior to), any amount of coverage that does not require medical information $50,000 or less) will be effective on your Eligibility Date.
- If you and your spouse apply within 31 days following your Eligibility Date, any amount of coverage that does not require medical information ($50,000 or less) will be effective on the date the application form was signed. Your Human Resources Department must be in receipt of your signed application form within the 31 days following your Eligibility Date for coverage to be effective.
- If you apply for amounts that exceed $50,000 during your eligibility period, you will be required to complete a medical questionnaire. If approved, you will be notified by Sun Life of the date your coverage will be effective.

If you apply for coverage after your 31-day eligibility period, medical information will be required for all amounts of coverage applied for.

Insured Critical Illness Conditions

The Colleges of Applied Arts and Technology Critical Illness insurance plan covers a broad range of conditions – 25 in total – as follows:

1. Cancer
2. Heart Attack (Myocardial Infarction)
3. Stroke
4. Aorta surgery
5. Major organ transplant
6. Major burns
7. Major organ failure requiring transplant
8. Kidney Failure
9. Alzheimer’s disease
10. Loss of speech
11. Parkinson’s disease
12. Coronary artery bypass surgery
13. Blindness
14. Multiple Sclerosis
15. Loss of independent existence
16. Deafness
17. Paralysis
18. Coma
19. Benign brain tumour
20. Occupational HIV Infection
21. Aplastic anemia
22. Bacterial meningitis
23. Heart valve replacement or repair
24. Loss of limbs
25. Motor neuron disease

For further description of these disabilities please ask your College Benefit Administrator for the "Critical Illness Insurance" brochure.

Limitations and Exclusions

No benefits are payable for claims resulting from:

- Declared or undeclared war, insurrection or rebellion
- Voluntary participation in a riot or act of civil disobedience
- Attempted suicide, or intentionally self-inflicted injuries while sane or self-inflicted injuries while insane
- Committing or attempting to commit a criminal offence
- Use of illegal or illicit drugs or substances, misuse of drugs or alcohol
- Any symptom or medical problem, leading to a diagnosis of cancer, which commenced within 90 days following the first premium due date
- Death during the required survival period
- For any coverage that does not require health information ($50,000 or less), no benefit is payable for any covered condition that occurs within 12 months after the effective date of the insured person's coverage, and that resulted from any injury, sickness or medical condition (whether or not diagnosed) for which, during the 12 months prior to the effective date of insurance, the insured person:
  - had symptoms
  - consulted a physician or other health care practitioner, or
- was provided any health-related care, advice or treatment, or that a reasonable prudent person, with such injury, sickness or medical condition, would have consulted a physician or any other health care practitioner.

Coverage Ends

Your Critical Illness Insurance coverage will end on the earliest of:

- the day you retire;
- the day you reach age 65;
- the date you no longer a resident of Canada;
- the day the benefit is paid for the first covered condition;
- the day your employment ends;
- the day the group contract ends;
- the end of the period for which premiums have been paid; or
- the day of your death.

Your Spouse’s Critical Illness coverage will end on the earlier of:

- the day your spouse no longer qualifies under the definition;
- the day you or your spouse reach age 65;
- the day your spouse no longer resides in Canada;
- the day the benefit is paid for the first covered condition;
- the day your employment ends;
- the day the group contract ends;
- the end of the period for which premiums have been paid; or
- the day of your death or the day of your spouse’s death.

Coverage Conversion

If you lose your Critical Illness insurance coverage through a change in employment, marital status or retire, you and/or your spouse can maintain your coverage up to a maximum of $100,000 by calling Sun Life Financial within 31 days of loss of coverage. If you reach age 65, therefore your coverage terminates, your spouse is still eligible to convert their coverage (up to a maximum of $100,000) if they are under the age of 65.
Note: Not eligible to convert coverage after age 65.

How to Apply

To apply for coverage, contact your College Benefits Administrator to obtain an enrolment package.

Section 17 - Submission of Claims

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

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

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

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or

- regarding claims for disability benefits that have been paid by Sun Life for some period of time, more than one year after the last date for which disability benefits have been paid, or

- regarding all other claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim, or
- regarding claims for *Coverage during total disability* which are initially approved, more than one year after the date you cease to be covered or your premiums cease to be waived.

Making an Extended Health Care Claim

Drug Card Plan

The drug card is used for prescription drugs only. The card is accepted at most drug stores across Canada. Other claims, such as physiotherapy or medical supplies, are not covered under the drug card plan and receipts must be submitted to Sun Life using the Extended Health Care claim form to obtain reimbursement. The drug card cannot be used outside of Canada. These claims must be submitted to Sun Life using the Extended Health Care claim form.

What happens if I do not used the drug card to purchase my drugs

If you do not use the card for all your drug purchases, your reimbursement could be affected due to pharmacy mark-ups on the cost of the drugs. This means that you may have to pay more out-of pocket.

Time limits for filing a claim

Claims must be received by Sun Life within the earliest of:

- 548 days (18 months) following the date on which the expense was incurred,
- 90 days following the end of your Extended Health Care coverage, or the termination of the Extended Health Care provision.

Before submitting a claim you will need to consider the co-ordination of benefits provisions applicable, if you are covered by more than one group insurance plan, to make sure that you are submitting the claims appropriately.

Co-ordination of benefits
(Coverage under more than one plan)

If you are covered for Extended Health Care under this Plan and you and your spouse are covered under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards.

These standards determine where you should send a claim first. Here are some guidelines:

- if you are claiming expenses for your spouse and the spouse is covered for those expenses under another plan, you must send the claim to your spouse's plan first.
- if you are claiming expenses for your children, and both you and your spouse have coverage under different plans, you must claim under the plan of the parent with the earlier birthday (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 maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.
- if your spouse is over age 65 and eligible for coverage under the Ontario Drug Benefit Program (ODB) there are specific rules to follow. Contact your College Benefits Administrator for further details.

Ontario Assistive Devices Program

The Ontario Assistive Devices Program (ADP), run by the Ontario Ministry of Health, helps people who have long-term physical disabilities get needed equipment and supplies. To find out more about this program, contact the Assistive Devices Branch of the Ministry of Health.

The Claims Process

If you are submitting your first claim for benefits, the claim form can be obtained from your College Benefits Administrator or on the Sun Life Financial Plan Member Services website at www.mysunlife.ca. Sun Life will send the payment directly to you along with a pre-printed claim form for you to use when you submit your next claim.

In the event you misplace your personalized claim form, a generic form can be obtained from your College Benefits Administrator.

Contacting Sun Life

Sun Life's web address is: www.sunlife.ca
Sun Life's e-mail address is askus@sunlife.com
Sun Life's number in Toronto is 416-753-4300
Sun Life's toll-free number is 1-800-361-6212
Should you require assistance, please contact your College Benefits Administrator to obtain a brochure with additional information on Sun Life contacts.

Private Duty Nursing Claims

Private Duty Nursing Services must be ordered by a doctor for the treatment of an illness. In addition to the claim form and the receipt for the expenses, you must include a letter from your doctor. This letter should describe the nature of your disability or your Dependent's disability, a diagnosis, how the particular service will improve/stabilize your or the patient's condition and the length of time the service will be required.

Medical Supplies and Equipment

Medical supplies and equipment must be ordered by a doctor for the treatment of an illness. In addition to the claim form and the receipt for the expenses, you must include a letter from your doctor. This letter should describe the nature of your disability or your Dependent's disability, a diagnosis, how the particular supplies or equipment will improve/stabilize your or the patient's condition and the length of time the supplies or equipment will be required.

How long will it take for my claim to be processed?

Provided you have sent all the necessary information and completed the form satisfactorily your claim should be processed within 7 days.

Following up on a claim

In the event a payment has taken longer than anticipated you may follow-up on the status of the payment by contacting Sun Life directly.

I am the survivor of a deceased employee. How do I make a claim for benefit?

If you are entitled to and have elected survivor benefits, follow the process stated above. You were assigned a new certificate (identification) number immediately upon notifying the College of the death of your spouse. Use this number and not the certificate number of your deceased spouse for any claims incurred after the death of your spouse.

Out-of-Province Claims

Contact Europe Assistance USA, Inc. in case of an emergency.

Prior to leaving the province print your personalized travel card from Sun Life's website at www.mysunlife.ca.

OHIP first

- Your claim for expenses incurred outside the province must be submitted to OHIP first.
- Original receipts should be included with your claim and you should keep a copy for your records.

Sun Life second

- The balance of the claim not paid by OHIP should be submitted to Sun Life, using the normal claim form for your Group.
- The OHIP reimbursement statement and copies of your receipts should be attached to the Sun Life claim form.
- Be sure to keep a copy of the information sent to Sun Life for your records.

Contacting Sun Life

Sun Life's web address is: www.sunlife.ca
Sun Life's e-mail address is: askus@sunlife.com
Sun Life's number in Toronto is: 416-753-4300
Sun Life's toll-free number is: 1-800-361-6212

Should you require assistance, please contact your College Benefits Administrator to obtain a brochure with additional information on Sun Life contacts.

Making a Dental Claim

Time limits for filing a claim

In order to pay benefits, Sun Life must receive a claim no later than the earliest of:

- the end of the calendar year following the year during which you incur the expenses.
- 90 days following the end of your Dental Care coverage or termination of the Dental Care provision.

Co-ordination of benefits
(Coverage under more than one plan)

If you or your spouse are covered for Dental Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards.

The Claims Process

Claims can be submitted electronically by your dentist, or if you are submitting your first claim for benefits, the claim form can be obtained from your College Benefits Administrator.

Sun Life will send the payment directly to you along with a pre-printed claim form for you to use when you submit your next claim. Each time you file a claim you must follow the same process.

- ask your Dentist to complete the applicable sections of the claim form.
- you complete the applicable sections of the claim form, sign it, attach any relevant information and forward it to the Sun Life claims office. The appropriate address is noted on the claim form.
- keep a copy of the claim form and your receipts for future reference.

If your Dentist is submitting the claim electronically:

- Your Dentist is required to complete the applicable sections of the claim form.
- You complete the applicable sections of the claim form and sign it.

Your Dentist electronically forwards the claim directly to Sun Life and the payment is generated immediately. If you have assigned payment to the dentist, payment will be made directly to the Dentist. If payment is to be made to you and you have set up a direct deposit with Sun Life (www.mysunlife.ca) the payment will be deposited to your account within a couple of days. Otherwise, a cheque will be mailed to your home address.

In the event you misplace your personalized claim form, a generic form can be obtained from your College Benefits Administrator.

Orthodontic Claims

Although most orthodontists will quote a single amount for the full course of treatment covering several years, orthodontic expenses will be reimbursed based on a monthly or quarterly basis as treatment is rendered. The Plan will not prepay services that have not been rendered.

How long will it take for my claim to be processed?

Provided you have sent all the necessary information and the claim form has been completed satisfactorily, your claim should be processed within 7 days.

Following up on a claim

In the event a payment has taken longer than anticipated, you may follow-up on the status of the payment by contacting Sun Life directly.

Contacting Sun Life

Sun Life's web address is: www.sunlife.ca
Sun Life's e-mail address is: askus@sunlife.com
Sun Life's number in Toronto is: 416-753-4300
Sun Life's toll-free number is : 1-800-361-6212
Should you require assistance, please contact your College Benefits Administrator to obtain a brochure with additional information on Sun Life contacts.

Making a Claim for Long Term Disability Benefits

When and how to make a claim

You are responsible for notifying your College that you are disabled and obtaining the following forms from your College Benefits Administrator:

Your responsibilities

(a) Plan member's Statement.
(b) Consent for Service Canada and Insurer to Communicate Disability Benefit Information.
(c) Irrevocable consent to Deduct and Pay Insurer.
(d) Application for Canada Pension Plan (CPP) Disability benefits.
(e) Attending Physician's Statement.

Your claim for Long Term Disability should be submitted as soon as possible, usually two months prior to completion of the elimination period.

You complete forms a, b and c and forward them to Sun Life.

You must sign the Attending Physician's Statement. (form e) and give it to your doctor. You must also contact the Income Security Program office, Human Resources Development Canada, to make an application for Canada Pension Plan disability benefits (form d).

You are responsible for payment of any charges for having medical forms completed. These forms include those described above, supplementary medical statements and any other forms that may have to be completed by your doctor.

Your doctor's responsibility

Once your doctor has completed the Attending Physician's Statement, you or your doctor may send it directly to Sun Life or, if you prefer, you may return it to your College Benefits Administrator to send to Sun Life.

Your employer's responsibility

The College must complete the Employer's Statement and forward it to Sun Life.

Time lines for making a claim

A claim should be made no later than 90 days after you complete your elimination period. Ceasing to be actively at work with the College does not, by itself, mean that you are totally disabled.

Failure to furnish such proof within the time required may not invalidate nor reduce any claim if Sun Life determines that such proof was furnished as soon as was reasonably possible. Except in the absence of legal capacity, however, such proof must be furnished no later than one year from the time proof is otherwise required.

Claim is received by Sun Life

Sun Life will begin processing your claim once all the completed claim forms have been received.

Your claim cannot be processed until Sun Life has received the Employee's Statement (including the Consent for Service Canada and

Insurer to Communicate Disability Benefit Information), Employer's Statement and the Attending Physician's Statement.

Incomplete or additional information

If additional information is needed to make a decision on your claim, Sun Life will notify the College by letter as soon as possible. Your College Benefits Administrator will, in turn, notify you that further information is needed. Any expenses associated with acquiring the additional information will be your responsibility.

Claim is reviewed by Sun Life

Sun Life claims personnel and practising doctors review your claim to determine if you qualify for disability benefits in accordance with the terms of your contract. The nature of the claim will determine whether a specialist(s) report(s) is required.

How will I know if my claim has been processed?

Sun Life will send the College a letter confirming the amount of your disability benefits, the date they will commence and the duration for which benefits are approved (if known). Your College Benefits Administrator will forward this information along to you.

How long will it take to process my LTD claim?

Assuming all the forms have been completed fully and no follow-up is required by Sun Life, it takes approximately 4-6 weeks for a Long Term Disability claim to be processed.

If there are any complications with the forms, additional time would be added to the process resulting in a period of time when you could be without remuneration.

Every attempt is made to ensure this does not happen. Continuous contact between you and your College Benefits Administrator will help to minimise the situation. In this event, you may apply for Employment Insurance Sick benefits.

What can I do if my claim is declined?

Sun Life will advise the College Benefits Administrator that your claim has been denied and Sun Life will provide an outline of the procedures and the type of medical information required for reconsideration of your claim.
You may respond to this decision by:

- appealing this decision through the Sun Life appeal process
- pursuing your appeal with your College Benefits administrator
- contacting your local union office
- contacting a member of the Joint Insurance Committee (JIC) Information about the JIC is contained in the Academic Collective Agreement.

Your claim will be reconsidered provided you submit new medical information for review. In order to effectively re-evaluate your claim,

all outstanding information requested in the decline letter should be provided.

Discrepancies in benefit payment amounts

It is recommended that you check your benefit payment amount each month to ensure it is correct. In the event you discover there is a discrepancy, it is important for you to contact your College Benefits Administrator so that the appropriate adjustment can be made. If you have been overpaid, a re-payment arrangement can be worked out for you; if you have been underpaid, Sun Life will be required to make the correction and issue payment.

Making a Life Insurance Claim

How to make a claim

Your College Benefits Administrator must be contacted immediately, and will assist you or your beneficiary with the process associated with filing a death claim.

Your Death Claim

In the event of your death, the following must occur as soon as possible after your death:

- A claim form must be completed by the College.
- A claim form must be completed by your beneficiary.
- The completed claim forms along with a death certificate from your attending doctor or funeral director must be forwarded to Sun Life in order for the claim to be adjudicated.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

For Accidental Death & Dismemberment Claims Applicable only to employees

If you suffer a loss other than death, ***the following must occur*** within 6 months of the loss:

- A claim form must be completed by the College.
- A claim form must be completed by you.
- The completed claim forms along with an Attending Physician's Statement clearly indicating the date and details of the accident, the nature of the injury, the date of loss and the degree of loss, must be forwarded to Sun Life in order for the claim to be adjudicated.

Death Claim for your Dependent(s)

In the event of the death of a Dependent, ***the following must occur*** as soon as possible after the death of a Dependent:

- A claim form must be completed by the College.
- A claim form must be completed by you.
- The completed claim forms along with a death certificate from your Dependent's attending doctor or funeral director must be forwarded to Sun Life in order for the claim to be adjudicated.

It normally takes 3-4 weeks to process a claim, however this may vary depending on the circumstances of each case. Sun Life will make every effort to keep the College Benefits Administrator informed of the status of the claim.

Making a Critical Illness Insurance Claim

How to make a claim

Your Benefits Administrator must be contacted immediately, and will assist you with the process associated with filing a claim.

Your Critical Illness Claim

In the event you are diagnosed with one or more of the insured Critical Illness conditions, the following must occur as soon as possible after your diagnosis;

- a claim form must be completed by you
- the completed claim form along with supporting medical evidence must be forwarded to Sun Life in order for the claim to be adjudicated

If you have any questions about your claim, please contact your Benefits Administrator or Sun Life's customer Service department toll-free at 1-800-669-7921 (or in the Toronto area call 416-408-7390).

It normally takes 3-4 weeks to process a claim, however, this may vary depending on the circumstances of each case. Sun Life makes every effort to keep the Benefits Administrator informed of the status of the claim.

You may send the completed claim form directly to Sun Life at the following address:

Sun Life Assurance Company of Canada
Association & Affinity Business
P.O.Box 4097, Station A
Toronto, ON M5W 2Z5

Respecting your privacy

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

You have a choice

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

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