

your **group**
benefits



Mount Pleasant Group

Seasonal employees

Contract Number 50958
Class 5
Effective January 1, 2018 (Version 2)

WELCOME TO YOUR GROUP BENEFIT PROGRAM

As a valued employee, you are entitled to the medical and financial security of the Group Benefit program, provided through Sun Life Assurance Company of Canada (Sun Life) – Contract No. 50958.

This benefit booklet has been designed with your needs in mind, providing easy access to pertinent information. Please review it carefully.

Group Benefits are an integral part of the compensation you receive from the organization. They are important, not only for the financial assistance they provide, but for the security they offer to you and your insured dependents.

For questions regarding the status of a claim, please call Sun Life of Canada claims hotline service at (416) 753-4300 or 1-800-361-6212. You can also access your personal medical and dental benefits information on the Internet at www.mysunlife.ca.

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General Information

About this booklet

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

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

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

Any reference to your employer or to the Mount Pleasant Group includes Mount Pleasant Group of Cemeteries and Canadian Memorial Services (operating as The Simple Alternative).

The contract holder, Mount Pleasant Group, has the sole legal and financial liability for the Health Spending Account benefit. Sun Life only acts as administrator on behalf of the contract holder for this benefit.

All other benefits are insured by Sun Life Assurance Company of Canada.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are a seasonal employee.
- you are actively working for your employer at least 40 hours a week.

- you are covered by the collective agreement.
- you have completed the waiting period.

The waiting period for your group plan ends after you have completed 3,000 hours of work.

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

Your dependents become eligible for coverage on the first day of the following month after you apply for dependent coverage. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

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

To be eligible, your spouse must be lawfully married to you through an ecclesiastical or civil ceremony and is currently cohabiting and residing with you; or

If there is no such person as described above, your partner must have been cohabiting and residing with you for a continuous period of at least one year, and has been publicly represented by you as your spouse.

A spouse is no longer eligible for benefit coverage once you are legally separated, divorced or no longer cohabiting and residing together. A spouse may be of the same or opposite gender. You can only cover one spouse at a time under this plan.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal

union recognized by law, and are under age 23.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 as long as the child is entirely dependent on you for financial support.

Effective March 1, 2018 - If a dependent is studying outside Canada, it is important that you contact your employer to request an extension of coverage for the dependent.

Effective March 1, 2018 - A *Plan Sponsor request to continue group coverage* form will need to be completed and submitted to Sun Life for approval. The approval will only be valid for a period of one year. To renew the continuation of benefits for your dependent, a new *Plan Sponsor request to continue group coverage* form will need to be completed and submitted to Sun Life for approval.

Effective March 1, 2018 - In addition, provincial health coverage must be in effect during the entire period the dependent is studying outside Canada. Contact the local office of your Provincial Health Care Plan to arrange for extended coverage.

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

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

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

Enrolment

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

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

You must elect the Extended Health Care coverage under this plan to be eligible for the Health Spending Account benefit.

When coverage begins

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

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

Dependent coverage begins on the first day of the following month after you apply for dependent coverage.

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

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

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

Changes affecting your coverage

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

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

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

- if you are not actively working when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.

- if a dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependent's coverage cannot take effect before the dependent is discharged and is actively pursuing normal activities.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to your employer:

- change of dependents.
- change of name.

Accessing your records

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

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

- the date your employment ends or you retire.
- the date you are no longer actively working.

- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

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

Replacement coverage

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

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

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

Making claims

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

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

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

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

Legal actions for insured benefits

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Legal actions for self-insured benefits

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

Coordination of benefits

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

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

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

The maximum amount that you can receive from all plans for eligible

expenses is 100% of actual expenses.

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

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

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

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

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

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

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

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

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

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

Government cut-back freeze Benefits provided in conjunction with government sponsored programs are based on the presumption that the services or supplies currently payable under such programs will not be reduced or eliminated. If the coverage of a service is reduced or eliminated after June 17, 1999, then the portion of the cost which the government program ceases to cover will not be automatically covered by this contract. The contract holder and Sun Life will determine whether all or part of the expenses will be covered under this contract.

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

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

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

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

Retirement date If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

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

Extended Health Care (Medicare Supplement)

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

Deductible The deductible is the portion of claims that you are responsible for paying.

Benefit year maximum Under Extended Health Care, the maximum amount we will pay for any person is \$1,500.

Prescription drugs Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*.

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a 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.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$600 for each person.
- vitamin B6 and B12 injections for the treatment of obesity. These injections are covered at 50%, after you pay the deductible.
- drugs for the treatment of infertility, up to a lifetime maximum of \$2,400 for each person.
- oral drugs for the treatment of sexual dysfunction, up to a lifetime maximum of \$2,400 for each person.
- Durolane injections.
- vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

We will cover 80% of the cost of the above drugs and supplies after you pay the deductible.

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

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

-
- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
 - the cost of giving injections, serums and vaccines.
 - treatments for weight loss, including drugs, proteins and food or dietary supplements, except as otherwise provided under the list of eligible expenses above.
 - hair growth stimulants.
 - Synvisc and Suplasyn injections.
 - 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.

Drug evaluation The following drugs will be evaluated and must be approved by us to be eligible for coverage:

- drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
- drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

We will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations

and provinces.

- availability of other drugs treating the same or similar conditions(s).
- plan sustainability.

<i>Dispensing fee</i>	Eligible expenses for the dispensing fee are limited to \$8 for each prescription or refill.
<i>Drug substitution limit</i>	Charges in excess of the lowest priced equivalent drug are not covered unless specifically approved by Sun Life. To assess the medical necessity of a higher priced drug, Sun Life will require you and your doctor to complete and submit an exception form.
<i>Prior authorization program</i>	<p>The prior authorization (PA) program applies to a limited number of drugs and, as its name suggests, prior approval is required for coverage under the program. If you submit a claim for a drug included in the PA program and you have not been pre-approved, your claim will be declined.</p> <p>In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form.</p> <p>You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as:</p> <ul style="list-style-type: none">■ Health Canada Product Monograph.■ recognized clinical guidelines.■ comparative analysis of the drug cost and its clinical effectiveness.■ recommendations by health technology assessment organizations and provinces.

- your response to preferred drug therapy.

If not, your claim will be declined.

Our prior authorization forms are available from the following sources:

- our website at www.mysunlife.ca/priorauthorization
- our Customer Care centre by calling toll-free 1-800-361-6212

Other health professionals allowed to prescribe drugs

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

When coverage ends

Extended Health Care coverage will end when the employee is no longer actively at work or no longer covered by the terms of the collective agreement. Please refer to page 5 of this employee benefits booklet for further details.

Payments after coverage ends

If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability if the expenses are incurred:

- during the uninterrupted period of total disability,
- within 90 days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependent is totally disabled if prevented by illness from performing the dependent's normal activities.

What is not covered

We will not pay for the costs of:

- utilization fees or annual doctor's fees for general items such as doctor's notes, prescription refills, calls from pharmacists, etc.

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

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

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

We will also not pay benefits when compensation is available under a private benefit plan providing income for time lost due to a work related accident or illness, a Criminal Injuries Compensation Act or similar legislation.

Integration with government programs

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

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

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

When and how to make a claim

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

In order for you to receive benefits, we must receive the claim the earlier of:

- 12 months after the date you incur the expenses, or
- 3 months after the end of your Extended Health Care coverage.

Dental Care

**General description
of the coverage**

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

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

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

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

When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

The benefit year is from January 1 to December 31.

Deductible	There is no deductible for this coverage.
Benefit year maximum	<p>We will not pay more than \$1,500 per person for each benefit year for Basic and Major dental procedures combined.</p> <p>If your coverage starts in the second half of a benefit year, the maximum amount for that benefit year will be reduced by 50%.</p>
Predetermination	We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.
Preventive dental procedures	<p>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.</p> <p>We will pay 80% of the eligible expenses for these procedures.</p>
<i>Oral examinations</i>	<p>1 complete examination every 3 years.</p> <p>1 recall examination every 9 months.</p> <p>Emergency or specific examinations.</p>
<i>X-rays</i>	<p>1 complete series of x-rays or 1 panorex every 3 years.</p> <p>Bitewing x-rays, limited to 1 set every 9 months.</p> <p>X-rays to diagnose a symptom or examine progress of a particular course of treatment.</p>
<i>Other services</i>	<p>Required consultations with another dentist.</p> <p>Polishing (cleaning of teeth) and topical fluoride treatment, once every 9 months.</p>

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing primary teeth, limited to children under 18 years of age.

Pit and fissure sealants. Only children under 18 years of age are covered for this treatment.

Oral hygiene instruction, up to a maximum of 1 session per benefit year.

Basic dental procedures

Your dental benefits include procedures used to treat basic dental problems.

We will pay 80% of the eligible expenses for these procedures.

Fillings Amalgam, composite, acrylic, or equivalent.

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

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

Endodontics 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.

Scaling, root planing, or occlusal equilibration, limited to 12 units per benefit year combined.

Oral surgery Surgery and related anaesthesia, other than: removal of impacted teeth (*Preventive dental procedures*), implants and transplants, and repositioning of the jaw.

Major dental procedures	<p>Your dental benefits include procedures used to treat major dental problems.</p> <p>We will pay 50% of the eligible expenses for these procedures.</p>
<i>Major restorations</i>	<p>Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (<i>Basic dental procedures</i>).</p>
When coverage ends	<p>Dental coverage will end when the employee is no longer actively at work or no longer covered by the terms of the collective agreement. Please refer to page 5 of this employee benefits booklet for further details.</p>
Payments after coverage ends	<p>If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.</p>
What is not covered	<p>We will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.</p> <p>We will not pay for services or supplies that are not usually provided to treat a dental problem.</p> <p>We will not pay for:</p> <ul style="list-style-type: none">■ procedures performed primarily to improve appearance.■ the replacement of dental appliances that are lost, misplaced or stolen.■ charges for appointments that you do not keep.■ charges for completing claim forms.■ services or supplies for which no charge would have been made in the absence of this coverage.■ supplies usually intended for sport or home use, for example,

mouthguards.

- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- charges related to the temporomandibular joint (TMJ) treatment.
- charges related to implants, including surgery charges.
- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.

We will not pay benefits when compensation is available under a private benefit plan providing income for time lost due to a work related accident or illness.

When and how to make a claim

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

In order for you to receive benefits, we must receive a claim the earlier of:

- 12 months after the date you incur the expenses, or
- 3 months after the end of your Dental Care coverage.

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

Health Spending Account

General description of the coverage

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

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

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

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

The benefit year is from January 1 to December 31.

How your Health Spending Account works

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

Each time you submit a Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one benefit year cannot be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible

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

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

Continuation of coverage for dependents

The Health Spending Account is set up under the employee's name, and there cannot be any continuation of coverage for dependents after the employee's death. Only expenses incurred before the employee's death can be covered under the employee's Health Spending Account.

Plan credits

\$150 on the commencement of each benefit year

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

Eligible expenses

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

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| <i>Drugs</i> | ■ drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist. |
| <i>Eyeglasses</i> | ■ eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist. |
| <i>Deductibles and coinsurances</i> | ■ deductible and coinsurance amounts under medical or dental plans. |
| <i>Licensed practitioners (fee for services)</i> | ■ acupuncturists (must be a licensed medical practitioner), chiropractors, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapists. |
| <i>Dental care</i> | ■ preventative, diagnostic, restorative, orthodontic and therapeutic care. |
| <i>Attendant care</i> | ■ remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.

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

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- Facilities*
- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.
 - payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.
- Hospitals*
- payments to a public or licensed private hospital.
- Devices and supplies*
- artificial eyes.
 - artificial limbs.
 - crutches.
 - cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
 - device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of \$1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
 - device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.

- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.

- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.

- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
 - truss for a hernia.
 - walkers.
 - wheelchairs.
 - wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.
- Other*
- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
 - costs of medical services and supplies outside of the province of residence.
 - diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
 - modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
 - reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.

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- transportation by ambulance to or from public or licensed private hospital for the patient.
 - transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
 - equivalent medical services are not available locally.
 - the route is reasonably direct.
 - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
 - reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
 - reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

When coverage ends Your Health Spending Account coverage will end when you retire or reach age 70, whichever is earlier. Please refer to page 6 of this employee benefits booklet for further details.

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

When and how to make a claim To make a claim, complete the claim form that is available from your employer.

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

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

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