Sun Life Financial

your group benefits

Michaels
Where Creativity Happens®

Part-Time Employees in Saskatchewan

Group Policy No. 87015
Effective April 1, 2016
Issued November 23, 2017

Table of Contents

Your Group Insurance Booklet

Keep in a safe place

This booklet is a valuable source of information for you and your family. It provides the information you need about the group benefits available through your employer's group plan with Sun Life Assurance Company of Canada (Sun Life), a member of the Sun Life Financial group of companies. Please keep it in a safe place. We also recommend that you familiarize yourself with this information and refer to it when making a claim for group benefits.

The Group Benefits Administration (GBTA) Team at Sun Life is there to help

The GBTA Team can:

- help you enrol in the plan
- answer any questions you may have

Benefits and claims information at your fingertips

For more information about your group benefits or claims, please call Sun Life's GBTA Team directly at 1-866-881-0583.

We're on the Internet!

Learn more by surfing Sun Life's website. There's information about group benefits, and about Sun Life's products and services... and a whole lot more! Check us out!

Our address is:

www.sunlife.ca

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 policy.

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 Sun Life Financial Plan Member Services website at *www.mysunlife.ca*.
- our Sun Life Financial Customer Care centre by calling toll-free at 1-800-361-6212.

The statements in this booklet are only a summary of some of the provisions in the master policy. If you need further details on the provisions which apply to your group benefits you must refer to the master policy (available from the GBTA Team at Sun Life).

Summary of Insurance

Policy Number ***87015***

Life Insurance and Accidental Death and Dismemberment Insurance

Class of Members	Benefit Formula	Maximum Benefit
Part-Time Employees in Saskatchewan	1x annual earnings	$150,000*

***Evidence of Insurability:** is required for an increase in coverage of 25% or more of the existing coverage or $25,000, whichever is greater. Coverage will not take effect before Sun Life approves the evidence of insurability

Termination of Insurance: 70th birthday or retirement, if earlier

Extended Health Insurance

Part	Benefit	Deductible per family unit	Reimbursement
A	Drug: Pay Direct	$5.00 per prescription	50%
C	Hospital: ward to semi-private	none	50%
D	Supp. Health Care	none	50%
E	Out-of-Province Emergency and Travel Assistance	none	100%

Termination of Insurance: member's 70th birthday or retirement, if earlier

Dental Insurance (Employee only)

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/ Preventive	none	50%	$1,000*
B	Restorative	none	50%	*
D	Periodontic	none	50%	*
H	Endodontic	none	50%	*

*The maximum amount payable applies to the combined eligible expenses incurred in a calendar year under Parts A, B, D and H for you.

Termination of Insurance: member's 70th birthday or retirement, if earlier

Dental Fee Guide: The applicable fee guide is the one in force for general practitioners on the day when and in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. For expenses incurred in Alberta, or outside Canada by an Alberta resident, the applicable fee guide is the 1997 Alberta Fee Guide plus an inflationary adjustment determined by Sun Life.

General Information

Eligibility

You are eligible to be a member while you meet all of the following conditions:

1. You are actively working for Michaels of Canada ULC.
2. You have been continuously employed by Michaels of Canada ULC at least as long as the waiting period.
3. You are a resident of Saskatchewan, Canada.
4. You are not a full-time student, or a student enrolled in 60% of a full course load at a school, university, technical institute, regional college, or private vocational school.

You continue to be eligible while you regularly work for Michaels of Canada ULC for a minimum of 780 hours each year.

Participation is compulsory for Life and Accidental Death and Dismemberment Insurance.

If you are classified as a contract employee, owner-operator, consultant, independent or if you are self-employed, you are not eligible to join the plan.

Waiting Period - 390 hours during a period of 26 consecutive weeks from the date you began active work.

You are eligible, and continue to be eligible, for dependant insurance while you meet all of the following conditions:

1. You are a member.
2. You have at least one dependant.
3. Your dependants are residents of Canada.

Definitions

Dependant
means your spouse or a dependent child of you or your spouse. If Sun Life does not approve evidence of insurability required for a dependant, he will not be an insured dependant.

Dependent child
means a natural, adopted or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on you for maintenance and support and who is

1. under 21 years of age, or
2. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

He, his and him
refer to both genders.

Spouse

means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship for 12 consecutive months.

Enrolment

To enrol, you must submit a completed enrolment form. If you have a dependant, request dependant insurance when you enrol.

If you enrol more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability to Sun Life. If you request dependant insurance more than 31 days after you become eligible, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life.

If you have no dependant when you enrol and later acquire one, request dependant insurance, (eg. birth of first child, marriage).

If your new dependant is a common-law spouse, call Sun Life's GBTA Team directly at 1-866-881-0583 to find out how to enrol for dependant insurance.

For late entrants, evidence of insurability submitted to Sun Life is at your expense.

Effective Date

Your insurance is effective on the latest of

- the first of the month coinciding with or following the date that you became eligible,
- the date that you enrol for insurance, or
- the date that Sun Life approves your evidence of insurability.

Your dependant insurance is effective on the latest of

- the date that you become eligible for dependant insurance,
- the date that you request dependant insurance, or
- the date that Sun Life determines the insurability of all of your dependants and approves at least one dependant.

If you are absent from work on the date your insurance or your dependant insurance would be effective, then that insurance will not be effective until the date you return to active work.

Changes in Insurance

An increase in your benefits, the amount of your insurance or the amount of your dependant insurance due to change in your group benefit plan's design or a change in your classification becomes effective on the date of the change, unless you are not actively working on that day due to disease or injury.

If Sun Life doesn't approve an increase in the amount of your insurance or the amount of your dependant insurance, any future increase in the maximum benefit amount will not be effective unless evidence of insurability is approved. An increase in the maximum benefit amount will be effective on the date Sun Life approves the evidence of insurability.

If, due to disease or injury, you are not actively working on the date an increase in your benefits, the amount of your insurance or the amount of your dependant insurance would be effective, the increase becomes effective on the date you return to active work. Sun Life may require evidence of insurability to establish the date that you are physically and mentally fit to return to active work. If so, the increase becomes effective on the date Sun Life establishes. If Sun Life doesn't approve the evidence of insurability required, the increase will not be effective.

Subrogation

Subrogation is a legal practice giving Sun Life the right to be reimbursed for benefits paid to you if you have been compensated by another person who is responsible for your loss. The intent of subrogation is to limit your benefit payments to the amount you actually lost.

Let's assume a person is responsible for your disability, and is required to compensate you for any of the loss that results from your disability. If Sun Life is paying or has paid your loss of income benefits, you may be receiving more income than you earned before you became disabled. In that case, you would reimburse Sun Life for the loss of income benefits Sun Life has paid. If you receive an amount for future loss of income, that amount will reduce your future loss of income benefits from Sun Life.

Subrogation also applies to any medical and/or dental expenses you have been paid as a result of an injury caused by another person. Once you are compensated by the person who is responsible for your loss, you must reimburse Sun Life.

If subrogation applies to your claim, Sun Life will contact you to obtain the information required to proceed. You will be required to sign an undertaking to reimburse Sun Life for any amount recovered which exceeds 100% of income or expenses. Before agreeing to a settlement of your claim, Sun Life's approval must be obtained.

Comparable Coverage

If you are insured for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you may request the similar coverage offered under this plan.

If your dependant is insured for comparable coverage under another plan, you may decline the dependant coverage for the Extended Health coverage offered under this plan. If this comparable coverage stops, you may request the similar coverage offered under this plan.

The insurance that replaces the comparable coverage is effective on the date that the comparable coverage stops.

If you request the coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability to Sun Life. If you request the dependant coverage more than 31 days after the comparable coverage stops, you are considered a late entrant and you must submit evidence of insurability for each dependant to Sun Life. The insurance that replaces the comparable coverage is effective on the date that Sun Life approves the evidence of insurability. If Sun Life does not approve evidence of insurability required, the insurance will not be effective.

Termination of Insurance

Your insurance could terminate for a number of reasons. For example,

- you are no longer eligible, (i.e. you are no longer actively working),
- you reach the Termination Age,
- the provision or the policy terminates.

Member Life Insurance Provision

Benefit

The amount of benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or if the beneficiary has predeceased you, payment will be made to your estate.

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.

If you become totally disabled before age 65, your Life Insurance may be continued. Premiums for the continued insurance will be waived after you have been totally disabled from the same or related causes for six continuous months or, if you are also insured for group Long Term Disability Insurance with Sun Life, when you begin receiving group Long Term Disability payments.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. The claimant must submit proof of the claim and the right to receive the benefit to Sun Life.

If you become totally disabled and are also insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim along with your claim under the group Long Term Disability Insurance to Sun Life.

If you become totally disabled and are not insured for group Long Term Disability Insurance with Sun Life, you must submit a disability claim to Sun Life after you have been totally disabled continuously for 6 months but not beyond 12 months after the date you became totally disabled.

Limitation period for Ontario:

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

Exclusion

A "pre-existing" condition is one for which you received medical attention, consultation, diagnosis or treatment, during the 12 months before you became insured. Premiums will not be waived if a disability is related to a pre-existing condition and begins within 12 months of you becoming insured. This exclusion does not apply if you, after becoming insured, have been actively working for 3 consecutive months with no absence related to the pre-existing condition.

This exclusion does not apply to you if you were insured for similar coverage under a previous policy issued to this group, if the previous policy was replaced by this provision within 31 days of its termination.

At Termination

If your Life Insurance ends for any reason other than your request, you may apply to convert the group Life Insurance to an individual Life policy with Sun Life without providing evidence of insurability.

The request must be made within 31 days of the reduction or end of the Life Insurance.

There are a number of rules and conditions in the group policy that apply to converting this insurance, including the maximum amount that can be converted. Please call Sun Life's GBTA Team directly at 1-866-881-0583 for details.

Member Accidental Death and Dismemberment Insurance Provision

Benefit

The amount of death benefit will be paid to your beneficiary upon your death. If no beneficiary has been appointed or, if the beneficiary has predeceased you, we will pay your estate. The amount of dismemberment benefit will be paid to you.

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.

If a claim is submitted for Repatriation, we will pay your estate. If a claim is submitted for Occupational Training for Spouse, we will pay your spouse. If a claim is submitted for Education Benefit for Dependant Child, we will pay your dependent child.

Depending on the loss suffered by you, the amount of benefit is limited to the percentage shown in the Schedule of Losses.

Schedule of Losses

Loss of Life	100%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%
Loss of Both Hands, Both Feet or Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Speech and Hearing	100%
Loss of Use of Both Hands or Both Feet	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Arm or One Leg	75%
Loss of Use of One Arm or One Leg	75%
Loss of One Hand, One Foot or Sight of One Eye	67%
Loss of Use of One Hand or One Foot	67%
Loss of Speech or Hearing	50%

Loss of Hearing in One Ear	50%
Loss of Thumb and Index Finger of One Hand	33%
Loss of Four Fingers of One Hand	33%
Loss of All Toes of One Foot	25%

If you suffer more than one of the losses listed above as a result of one accident, Sun Life will pay the amount of benefit for only one loss. That loss will be the highest of the losses suffered by you.

When proof is received by Sun Life that you have suffered any of the losses due directly to bodily injury caused solely by an accident, the amount of benefit will be paid, provided all of the following conditions are met:

- The accident must occur while you are insured under this provision.
- The loss must occur within 365 days of the date of the accident.

If you become totally disabled, your Accidental Death and Dismemberment Insurance may be continued without payment of premiums as long as your Member Life Insurance premiums are waived.

Repatriation

If you suffer loss of life, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, for the preparation and transportation of your body from the place of the accident to your place of permanent residence.

The accidental death must occur at a distance of 150 kilometres or more from your place of permanent residence.

Rehabilitation

If you suffer any of the losses, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, to train you for active employment in an occupation for which you would not have engaged except for those injuries.

The expenses must be incurred within 2 years of the date of the accident.

No payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

Occupational Training for Spouse

If you suffer loss of life, we will pay the reasonable and customary expenses, limited to a maximum of $10,000, to enrol your spouse in an accredited occupational training program to qualify him for active employment in an occupation for which he would not otherwise have sufficient qualifications.

The expenses must be incurred within 3 years of the date of the accident.

No payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

Education Benefit for Dependent Child

If you suffer loss of life, we will pay the reasonable and customary tuition expenses to enrol your dependent child as a full-time student at a post-secondary institution provided

1. your dependent child is enrolled as a full-time student at a post-secondary institution at the time of the accident, or
2. your dependent child is a student at the secondary school level and, within 365 days of the date of the accident, he enrols as a full-time student at a post-secondary institution.

The maximum amount of benefit payable for each year that your dependent child is enrolled as a full-time student at a post-secondary institution will be the lesser of:

1. 5% of your amount of benefit, or
2. $5,000.

The amount of benefit will be paid each year, up to 4 consecutive years, after we receive proof that your dependent child is enrolled as a full-time student at a post-secondary institution.

No payment will be made for:

1. tuition expenses incurred before the date of the accident.
2. room or board or other ordinary living, travelling, or clothing expenses.

A post-secondary institution includes any accredited university, colleges d'enseignement general et professionnel, trade school, community college, or private college that provides an education above the secondary school level.

Claims

A death claim must be received by Sun Life within 6 years of the date of death. A claim for a loss must be received by Sun Life within 3 months of the date of the loss. All other claims must be received by Sun Life within 3 months of the date that the expense is incurred. The claimant must submit proof of claim and the right to receive the benefit to Sun Life.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for a loss directly or indirectly due to

1. suicide or self-inflicted injuries, regardless of whether you have a mental illness or intend or understand the consequences of your actions,
2. disease,
3. civil disorder or war, whether or not war was declared,
4. full-time service in the armed forces of any country,
5. injuries received while riding in, or on, or boarding or alighting from an aircraft if, when the injuries were received,
    a. you were operating, learning to operate or serving as a member of a crew of any aircraft, or
    b. the aircraft was being used for crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Extended Health Insurance Provision

Benefit

To qualify for the Extended Health coverage, you or your dependant must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

You will be reimbursed when you submit proof to Sun Life that you or your insured dependant has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. The total amount of eligible expenses you submit to Sun Life as a claim will be adjusted as follows:

1. the reimbursement percentage, which is the percentage of the eligible expense submitted that Sun Life will pay, is applied, and
2. the maximum is applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

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

Claims

A claim must be received by Sun Life within 18 months of the date that the expense is incurred. However, if your coverage terminates, any claim must be received by Sun Life no later than 90 days following the end of the coverage.

For the assessment of a claim, itemized bills, attending physician statements or other necessary information are required.

If your physician is recommending medical treatment that is expected to cost more than $1,000, you should request pre-authorization to ensure that the expenses are covered.

Limitation period for Ontario:

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

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,

- expenses for 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*,
- expenses for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

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

At Termination

If, on the date of termination of your insurance,

- you have a medically determinable physical or mental impairment due to injury or disease which prevents you from performing the regular duties of the occupation in which you participated just before the impairment started, regardless of the availability of work for you, or
- your insured dependant has a medically determinable physical or mental impairment due to injury or disease, is receiving treatment from a physician and is confined to a hospital or his home,

benefits will be payable for eligible expenses related to the impairment provided they are incurred within 90 days of the date of termination and this provision continues in force.

If you die, your insured dependant's Extended Health Insurance Benefits will be continued for 3 months without payment of premiums as long as the Extended Health Insurance provision remains in force. They will be contacted by the GBTA team.

My Health CHOICE Coverage

If your coverage under this plan terminates because your employment has ended, you may purchase Sun Life's My Health CHOICE coverage. This coverage is different from your group plan.

To be eligible for My Health CHOICE coverage, you must:

- apply for My Health CHOICE coverage within 60 days after the termination of your coverage,

- be under age 75 on the date you apply, and
- be a resident of Canada and be covered under the provincial health plan.

My Health CHOICE coverage may also include Dental coverage if you were covered for both Extended Health Care and Dental Care benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependents if those family members were covered under your group plan. Your spouse must be under age 75 on the date you apply for this coverage.

From time to time, Sun Life may review the eligibility requirements and, on the date you apply for My Health CHOICE coverage, they may be different from those listed in this booklet.

To apply for My Health CHOICE or if you have any questions, please call our Customer Solutions Centre at 1-877-893-9893.

Extended Health – Pay Direct Drug Benefit

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) in order to be eligible and be approved under *Drug evaluation*. There are additional eligibility requirements that apply, see Prior authorization program for details.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
5. needles, syringes, and chemical diagnostic aids for the treatment of diabetes.

Drug evaluation

The following drugs will be evaluated and must be approved by Sun Life to be eligible for coverage:

1. drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
2. 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 Sun Life's approval.

Sun Life 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 condition(s).
- plan sustainability.

Drug Substitution Limit

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 the insured person and the attending physician to complete and submit an exception form.

Prior Authorization Program

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 the insured person submits a claim for a drug included in the PA program and has not been pre-approved, the claim will be declined.

In order for drugs in the PA program to be covered, the insured person needs to provide medical information using Sun Life's PA form. Both the insured person and the attending physician need to complete parts of the form.

The insured person will be eligible for coverage for these drugs if the information provided by the insured person and the attending physician meets Sun Life's clinical criteria based on factors such as:

- 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.
- the insured person's response to preferred drug therapy.

If not, the claim will be declined.

The prior authorization forms are available from the following sources:

1. Sun Life's website at www.mysunlife.ca/priorauthorization
2. Sun Life's Customer Care centre by calling toll-free 1-800-361-6212

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your insured dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. any drug charges a person age 65 or over has to pay under a provincial drug plan,
3. expenses for drugs which do not legally require a prescription, except those specified under Eligible Expenses,
4. expenses for drugs which, in Sun Life's opinion, are experimental,
5. expenses for dietary supplements, vitamins and infant foods,

6. expenses for contraceptives (other than oral),
7. expenses for drugs which are used for cosmetic purposes,
8. expenses for drugs used for the treatment of sexual dysfunction,
9. expenses for drugs used for the treatment of obesity,
10. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
11. expenses for 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, and
12. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Hospital Benefit

Definitions

Hospital

means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges

mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the items of expense listed below:

1. accommodation in a hospital, limited to the difference between the charges for public ward and semi-private room for each day of hospitalization.
2. chronic care user fees or convalescent care user fees for room and board charges in a hospital, limited to a maximum of $20 per day for 120 days per calendar year.

Exclusion

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Supplementary Health Care Benefit

Definitions

Hospital
means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant, Licensed Practical Nurse
means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or bodily injury and prescribed by a physician.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.), registered nursing assistant (R.N.A.), certified nursing assistant (C.N.A.) or licensed practical nurse (L.P.N.) when provided in the patient's home, limited to a maximum of $10,000 in a calendar year. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A., or L.P.N.
2. the services of the following practitioners, limited to a combined maximum of $350 per calendar year.
   a. a physiotherapist,
   b. a registered massage therapist,
   c. a speech language pathologist,
   d. a psychologist,
   e. a chiropractor*, including one x-ray examination per calendar year,
   f. an osteopath*, including one x-ray examination per calendar year,
   g. a naturopath*, and
   h. a podiatrist or chiropodist*, including one x-ray examination per calendar year.

   * physician's prescription not required.

The practitioner must be registered with the appropriate association or registry. Where applicable, expenses for practitioners' services eligible under a provincial health care plan will not be reimbursed until your expenses exceed the annual maximums under your provincial plan.

3. the services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 12 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident. A physician's prescription is not required.
4. licensed ground ambulance service to and from the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.
6. orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist, limited to a maximum of $400 in a calendar year (Employee only).
7. hearing aids and repairs to them, excluding batteries, limited to a maximum of $500 for eligible expenses incurred during a 5 year period.
8. trusses and crutches.
9. braces, provided they are not solely for athletic use.
10. artificial limbs or other prosthetic appliances.
11. oxygen.
12. diagnostic laboratory and x-ray examinations.
13. wigs and hairpieces required as a result of chemotherapy or radiation treatment, limited to a maximum lifetime amount of $75.
14. mammary prosthesis, following mastectomy. Replacements are limited to once per 2 calendar years.
15. surgical brassieres following a mastectomy, limited to a maximum of 2 surgical brassieres in a calendar year.
16. rental, or purchase at Sun Life's option, of medically necessary durable equipment that meets the patient’s basic medical needs and is approved by Sun Life, limited to a calendar year maximum of $5,000. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:
    a. wheel chairs,
    b. wheel chair repairs, limited to a lifetime maximum of $250,
    c. walkers,
    d. hospital beds,
    e. traction kits.

17. the following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence.
    a. public ward accommodation and auxiliary hospital services in a general hospital limited to, after deducting the amount payable by a government plan, a maximum of $75 a day for 60 days in a calendar year.
    b. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

    Items of expense incurred outside Canada are eligible only if they are not offered in any province in Canada.
18. ***Effective November 1, 2017*** - Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, limited to a combined maximum of $4,000 in a calendar year. You must provide Sun Life with a physician's note confirming the diagnosis.

Exclusions

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the user of a service,
5. expenses incurred under any of the conditions listed on the Extended Health Insurance Provision page as an Exclusion.

Extended Health – Out-of-Province Emergency and Travel Assistance Benefit

To be insured for this benefit, you and your insured dependant must have provincial health care coverage. Expenses for hospital/medical services and travel assistance benefits are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside your home province,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 60 days of travelling on vacation or business outside your home province. Your 60 days of coverage starts on the day you or your insured dependant departs from your home province.

Definitions

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

Emergency services
mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your insured dependant have a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Family member
means you or your insured dependant.

Reasonable and customary charges
mean those which are usually made to a person without insurance for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Relative
means your spouse, parent, child, brother or sister.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact our Emergency Travel Assistance provider, AZGA Service Canada Inc. (Allianz Global Assistance). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global 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 Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global 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 we have the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the family member is medically stable to return to his province of residence.

Emergency Services Excluded from Coverage

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

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that we or Allianz Global Assistance, based on available medical evidence, determines that the family member can be returned to his province of residence, and he refuses to return.
4. services which are required for the same illness or injury for which the family member received emergency services, including any complications arising out of that illness or injury, if the family member had unreasonably refused or neglected to receive the recommended medical services.
5. where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Eligible Expenses for Hospital/Medical Services

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services, less the amount payable by a government plan:

1. public ward accommodation and auxiliary hospital services in a general hospital,
2. services of a physician,
3. economy air fare for the patient's return to his province of residence for medical treatment,
4. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation,
5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

The maximum lifetime amount payable for the above Eligible Expenses is $1,000,000 for you and for each insured dependant.

Expenses that are included as Eligible Expenses under Drug, Hospital or Supplementary Health Care benefits are also eligible while you or your insured dependant is travelling outside Canada. These expenses are subject to the deductibles and reimbursement percentages listed under the appropriate benefit in the Summary of Insurance.

Eligible Expenses for Travel Assistance Benefits

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services:

1. family assistance benefits, which include reimbursement for the cost of:
    a. return transportation for insured dependent children who are under the age of 16, or who are handicapped, if they are left unattended because you or your spouse is hospitalized outside your province of residence. Sun Life will arrange the transportation of the dependent child to your home, and if necessary, an escort will be provided to accompany him. The maximum payable for the return transportation is a one-way economy fare for each dependent child.
    b. return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
    c. visit of one relative, if a family member is hospitalized for more than 7 days while travelling without a relative. This includes meals and accommodation up to a maximum of $150 per day, and round-trip economy transportation, for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of his body.
    d. meals and accommodation up to a maximum of $150 per day per family, if a trip is extended because a family member is hospitalized.

    The combined maximum amount payable for the above family assistance benefits is $5,000 for one travel emergency.
2. return of a deceased family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. The maximum amount payable for the preparation and return of the deceased is $5,000. Preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased **includes** a basic shipping container, but **excludes** expenses for burial, such as burial caskets and urns.
3. return of a vehicle. If a family member is unable to operate a vehicle (owned or rented) because he is being returned to Canada for medical treatment, Sun Life will reimburse the cost of returning this vehicle to his province of residence, or the nearest appropriate rental agency. This benefit is also payable in the event of a family member's death. The maximum amount payable for returning the vehicle is $1,000.

Travel Assistance Services

Out-of-province and around-the-world services are provided through Allianz Global Assistance, a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Allianz Global Assistance will be able to provide you and your insured dependants with the following emergency assistance services during the first 60 days of travel:

1. physician and hospital referrals,
2. on-going monitoring of medical treatment if a family member is hospitalized,
3. coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer him to another hospital that is equipped to provide the required treatment,

4. payment assistance for hospital/medical expenses,
5. legal referrals,
6. a telephone interpretation service,
7. a message service for you, your family, friends and business associates.

Emergency Payment Assistance

Eligible Hospital/Medical Expenses:

To ensure payment of these expenses,

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Sun Life Travel card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Allianz Global Assistance will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your insured dependant.
3. You will be required to sign an authorization form allowing Allianz Global Assistance to recover any amounts payable by the provincial health care plan.
4. For expenses that require a percentage paid by you, or that are not covered under this plan or the provincial health care plan, you must reimburse Sun Life for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Allianz Global Assistance and they will coordinate payments with the provincial health care plan and Sun Life.

24 Hour Helpline

If emergency assistance is needed, a 24 hour helpline is available. Multilingual coordinators at Allianz Global Assistance can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The 24 hour helpline can assist you and your insured dependant if you have lost your passport or visa, if you need to find a local legal advisor, or if you require telephone interpretation services. You can also call the helpline and leave important messages for family, friends or business associates; likewise, they can call the helpline and leave messages for you while you travel. Allianz Global Assistance will hold such messages for 15 days.

When calling the 24 hour helpline, please be ready to state your Policy No., Certificate No., ID No., and Provincial Medical Insurance Plan/Health Card Number.

Please consult the telephone numbers on your Travel card.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your insured dependant due to an emergency which occurs more than 60 days after departure from your province of residence,
2. expenses incurred on a non-emergency or referral basis,
3. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Insurance Provision.

If you are covered as a retired employee, you and your insured dependants must return to your province of residence for at least 30 consecutive days before becoming eligible for another 60 days of coverage.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries. For more information on travelling conditions and the availability of Allianz Global Assistance services in a particular country, please call the appropriate 24 hour helpline.

Neither Sun Life nor Allianz Global Assistance is responsible for the availability, quality or results of the medical treatment received by you or your insured dependant, or for the failure to obtain medical treatment.

Dental Insurance Provision

Benefit

This dental plan is a means to help you to pay for your dental treatment. The services and procedures outlined in this booklet are not a treatment plan and should not determine the treatment and care decisions you and your dentist make. Your actual needs should determine these decisions.

You will be reimbursed when you submit proof to Sun Life that you have incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the deductible, which must be satisfied each calendar year, is subtracted,
2. the reimbursement percentage is applied, and
3. the maximums specified in the Summary of Insurance are applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Sun Life reserves the right to refuse any assignment of benefits under this provision.

Co-ordination of Benefits

If you are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

Claims

A claim must be received by Sun Life within 18 months of the date the expense is incurred. However, if your coverage terminates, any claim must be received by Sun Life no later than 90 days following the end of the coverage.

For the assessment of a claim, itemized bills, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other necessary information may be required.

If your dentist has recommended dental treatment that is expected to cost more than $500, or if your dentist has recommended dental treatment involving dentures, bridges or crowns, you may have your dentist prepare a pre-treatment plan that you can submit to Sun Life before you start treatment. For any other dental treatment, you can call Sun Life at 1 800 361-6212 to determine if the recommended dental treatment is eligible for payment.

Limitation period for Ontario:

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

Alternate Benefit

When deciding what will be paid for a procedure, Sun Life may take into account alternate procedures, services, courses of treatment and materials available, and may provide dental benefits based on the least costly procedure, service, course of treatment and materials which will produce a professionally adequate result that is consistent with current, accepted standards of dental practice.

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services performed by a person who is ordinarily a resident in the patient's home or who is closely related to the patient by blood or marriage,
- expenses 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.

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with. Laboratory charges are also limited to 66 2/3% of the fee for the procedure in the Dental Fee Guide shown on the Summary of Insurance.

Dental Insurance Provision – Diagnostic/Preventive Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examination and diagnosis
   - oral examination (once every 36 months),
   - limited/recall examination (once every 6 months),
   - limited periodontal examination (once every 6 months),
   - specific oral examination (once every 12 months),
   - emergency oral examination (once every 12 months),

b. tests and laboratory examinations
   - biopsy of oral tissue,
   - pulp vitality tests,

c. radiographs
   - complete series (once every 36 months),
   - periapical,
   - bitewing (once every 12 months),
   - panoramic (once every 24 months),

d. preventive services
   - dental polishing (once every 6 months),
   - topical application of fluoride phosphate (once every 12 months),
   - pit and fissure sealants (for persons under 19 years of age),
   - recontouring of teeth for functional reasons

e. habit breaking appliances

f. drug injections

g. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses for replacement of space maintainers which have been lost, stolen or mislaid,
4. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
5. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Restorative Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examinations
   - oral examinations

b. restoration
   - caries control,
   - trauma control,
   - amalgam (bonded amalgam fillings are paid at the non-bonded equivalent),
   - acrylic or composite resin (Primary teeth and permanent anteriors and bicuspids only; permanent molars are paid at the amalgam equivalent),
   - prefabricated restorations,

c. periodontics
   - non surgical services,
   - scaling and root planing (not exceeding 8 time units each year),

d. denture repairs (once every 36 months)

e. relining rebasing and tissue conditioning of dentures (once every 36 months)

f. surgical services
   - uncomplicated removals,
   - surgical removals and repositioning
   - surgical excision,
   - surgical incision,
   - fractures,
   - lacerations,
   - frenectomy,
   - miscellaneous surgical services,

g. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

h. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred for the treatment of malocclusion or for orthodontic treatment,
3. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Periodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. periodontics
   - surgical services,
   - post-surgical treatment,
   - adjunctive procedures,
   - occlusal adjustment/equilibration (not exceeding 4 time units every year),
   - appliances,
   - maintenance adjustments & repairs (once every 6 months),
   - post treatment evaluation,

b. major surgery
   - alveoloplasty,
   - enucleation of cyst,
   - dislocations,

c. x-rays
   - temporomandibular joint x-rays,

d. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses for replacement of periodontal appliances which have been lost, stolen or mislaid,
3. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Dental Insurance Provision – Endodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

a. examinations
   - oral examinations

b. endodontics
   - pulpotomy,
   - root canal therapy,
   - periapical services,
   - other endodontic procedures,
   - emergency procedures,

c. anaesthesia (if performed in conjunction with oral surgery)
   - general anaesthesia
   - deep sedation
   - conscious sedation

d. hemisection

e. laboratory procedures

Exclusions

No benefit is payable for

1. expenses for cosmetic services,
2. expenses incurred under any of the conditions listed on the Dental Insurance Provision page as an Exclusion or Limitation.

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

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).