your group benefits

Contract Number: 102662
Effective: April 1, 2022
Issued: June 16, 2022

Newfoundland Power Inc.

Retirees and surviving spouses under age 65 - on or after January 1, 2011

WHENEVER. WHEREVER. We'll be there.

NEWFOUNDLAND POWER
A FORTIS COMPANY

Sun Life Financial

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How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-866-896-6984.

For faster service, have your **group contract number** and **member ID** ready to enter into our automated telephone system.

Plan Member Services

Download the my Sun Life Mobile App!

- Free from the Apple App Store or Google Play, anytime
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

Access to mysunlife website

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

Prior Authorization Program

For the form:

- visit our website at www.mysunlife.ca/priorauthorization
- call a Sun Life Financial Customer Care representative toll-free at 1-866-896-6984

For the list of drugs:

- visit our website at www.mysunlife.ca/priorauthorization

Your Drug Card

Provided by your employer or online at www.mysunlife.ca.

Note: If you have refused Extended Health Care coverage under this plan, this drug card does not apply to you.

All other inquiries

Call 1-877-SUN-LIFE (1-877-786-5433).

Benefit Summary

Contract Number **102662**

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care

Benefit year	April 1, 2022 to December 31, 2022, and then from January 1 to December 31
Deductible	None
Reimbursement level	
Drug card plan	Included
Prescription drugs	100% for insulin and diabetic supplies 80% for all other eligible expenses Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation* We will cover 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 • vaccines • intrauterine devices (IUDs) and diaphragms • varicose vein injections There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.
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.

Dispensing fee	The dispensing fee is not covered
Drug substitution limit	We will not cover charges above the lowest priced equivalent drug unless the doctor specifies in writing that no substitution for the prescribed drug may be made
In-province hospital	100% of the difference between the cost of a ward and a semi-private room
Convalescent hospital	100% of the difference between the cost of a ward and a semi-private room, up to $50 per day for a maximum of 120 days for treatment of an illness due to the same or related causes
Non-emergency transportation	For a covered person – 100%, up to a calendar year maximum of: ■ $500 per person for in-province services ■ $1,000 per person for out-of-province services For a companion – 100%, up to a calendar year maximum of: ■ $500 per person for in-province services ■ $1,000 per person for out-of-province services
Medical services and equipment	100%
Paramedical services	100% up to a maximum of $500 per person per benefit year per specialty but no more than an overall combined maximum of $1,000 per person per benefit year for all the qualified paramedical practitioners listed below: • psychologists, social workers or clinical counsellors • massage therapists • speech therapists • naturopaths • osteopaths or osteopathic practitioners. A separate maximum of $35 per person per benefit year applies to x-ray examinations • chiropractors. A separate maximum of $25 per person per benefit year applies to x-ray examinations • podiatrists or chiropodists. A separate maximum of $35 per person per benefit year applies to x-ray examinations 100% up to a maximum of $1,000 per person per benefit year for physiotherapists 50% for visual therapy
Vision care	100% up to a maximum of $200 in any 12 month period for a person under age 18 or in any 24 month period for any other person Services of an ophthalmologist or licensed optometrist – 100% limited to one eye examination in any 12 month period for a person under age 18 or in any 24 month period for any other person Contact lenses for the treatment of specific medical conditions – 100% up to a maximum of $250 per person over 2 benefit years
Termination	When you reach age 65

Dental Care

Benefit year	April 1, 2022 to December 31, 2022, and then from January 1 to December 31

Deductible	None
Fee guide	The current fee guide in the province where the employee lives, regardless of where the treatment is received If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that specialty, then the fee guide approved by the provincial Dental Association for that specialist will be used
Reimbursement level	
Preventive procedures	100%
Basic procedures	Endodontics and periodontics, excluding occlusal equilibration – 80% Occlusal equilibration and all other procedures – 100%
Maximum benefit	
Benefit year maximum	$750 per person
Termination	When you reach age 65

Life

Employee Basic Life

Amount	2 times your annual basic earnings rounded to the next higher $1,000 Maximum – $2,000,000
Proof of good health	Approval required for coverage in excess of $1,000,000, and any increase in that coverage of 25% or more or $25,000, whichever is greater
Termination	When you reach age 65

Employee Optional Life

Amount	The amount for which you were covered on the day preceding retirement, or a lower amount if you choose Maximum – $500,000
Termination	When you reach age 65

Spouse Optional Life

Amount	The amount for which your spouse was covered on the day preceding your retirement, or a lower amount if you choose Maximum – $500,000
Termination	When you reach age 65 or when your spouse reaches age 65, whichever is earlier

Optional Dependent Life

Amount	At time of retirement, you can choose Optional Dependent Life Spouse – $10,000 Child – $5,000
Termination	When you reach age 65

Making Claims

There are time limits for making claims. You can find more on these time limits in the following chart. **If you fail to meet these time limits, you may not be entitled to some or all benefit payments**.

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Ask your employer for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Extended Health Care coverage.
Dental Care	Ask your employer for the form to complete, or get the form on our website. The dentist will have to complete a section of the form. You can also submit claims for some expenses electronically. For more information, ask your employer.	Up to the earlier of the following dates: • 90 days after the end of the benefit year during which the expense is incurred, or • 90 days after the end of your Dental Care coverage. If we consider it needed, we can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any other related information.
Life coverage	Ask your employer to provide the claim forms.	We must receive the claim form as soon as possible after the death occurred.

General Information

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.

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Talk to your employer.

Who is eligible to receive benefits?	To be eligible for group benefits, you must reside in Canada and meet all the following conditions: • you must have been covered under your employer's group plan on the day preceding retirement. • you are at least 55 years of age or older but under age 65. • you have completed 10 years of continuous service with your employer and its related companies prior to your retirement date or completed the combination of age plus service as outlined by the defined benefit plan. • you must be receiving a pension from your employer. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent.
Who qualifies as your dependent	Your dependent must be: • your spouse or your child, and • residing in Canada or the United States. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage. • under any other formal union recognized by law. • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least 12 months. You can only cover one spouse at a time. **Your children and your spouse's children** (other than foster children) are eligible dependents if they are under age 23 and do not have a spouse. A child who is a full-time student under age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse. **If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask your employer for more on this.**

When coverage begins	Your coverage begins on the date you become eligible for coverage. A dependent's coverage begins **on the later of** the following dates: • the date your coverage begins. • the date you first have a dependent.
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. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-866-896-6984.
When coverage ends	Your coverage will end on the earlier of the following dates: • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision 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 end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

If you die while covered by this plan

Extended Health Coverage for your dependents will continue until **the earlier of** the following dates:

- the date your surviving spouse reaches age 65.
- the date your spouse dies.
- the effective date of any similar coverage with another insurer.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the end of the period for which premiums have been paid for the dependent's coverage.
- the date the benefit provision under which the dependent is covered ends.

When dependent coverage continues, it is subject to all other terms of the plan.

Legal actions

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.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total eligible expenses.

When you have more than one plan, insurance industry standards determine which plan you should claim expenses from first.

Please send in claims for you and your spouse in the following order:

- First, send in the claim to the plan where the person is covered as an employee. If the person is an employee under two plans, send the claim to the different plans in the following order:
  - to the plan where the person is covered as an active full-time employee.
  - then, to the plan where they are covered as an active part-time employee.
  - then, to the plan where they are covered as a retiree.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

- First send in the claim to the plan where the child is covered as an employee.
- Then, to the plan where they are covered under a student health or dental plan through their educational institution.
- Then, to the plan of whichever parent has 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.

When you send us a claim, you must tell us about all other equivalent coverage that you or your dependents have.

Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefits.

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

Here are the definitions of some terms that appear in this employee booklet. Other definitions that describe specific benefits 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.
Basic earnings	Basic earnings are the salary you receive from your employer on the day proceeding your retirement, excluding any bonus, overtime or incentive pay.

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.

Extended Health Care

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 expenses that you incur while covered under this plan.

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed. 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 for treating an illness according to Canadian medical standards.

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

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

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

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	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.

What is not covered	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. • hair growth stimulants. • products to help you quit smoking. • drugs for the treatment of infertility. • drugs for the treatment of sexual dysfunction. • 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 condition(s). • plan sustainability.
Prior authorization program	The prior authorization (PA) program applies to a limited number of drugs, where you must get approval in advance for coverage under the program. 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. 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: • 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. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.
Reference Drug Program	The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will: • group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).

	• determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness. • limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*). • apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic category*. For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a non-*Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a non-*Reference Drug* depending upon the *therapeutic category* and such factors as: • clinical support for switching to the *Reference Drug*. • expected duration of treatment. • provincial programs. Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a non-*Reference Drug*. When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the non-*Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

Hospital expenses in your province

Hospital	We will cover the cost of room and board in a hospital in the province where you live, as indicated in the Benefit Summary. A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.
Convalescent hospital	We will cover the cost of room and board in a convalescent hospital, as indicated in the Benefit Summary, if this care has been ordered by a doctor and as long as it is primarily for rehabilitation, and not for custodial care. A *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Non-emergency transportation services

Non-emergency transportation services	Sun Life will cover the cost of non-emergency transportation services for a covered person requiring treatment and one companion. Sun Life will cover the cost of transportation by rail, boat, air or private automobile, for a covered person to and from the nearest centre where required medical treatment by a specialist or hospital is available, if: • written referral for non-emergency treatment is provided by the covered person's attending doctor, • written confirmation of the covered person's appointment with a specialist is provided by the specialist or hospital, or • the covered person is travelling for the purpose of receiving physiotherapy treatments. If travel is by private automobile, reimbursement will be based on the rate of $0.28 per kilometre and calculated on the distance from the city/town of residence to the city/town where treatment is received, but no more than the actual expenses incurred (receipts must be submitted). The distance travelled by the most direct route must be at least 50 kilometres one way or 100 kilometres round trip. Sun Life will not pay for the costs of: • meals or accommodations expenses. • transportation services relating to any cosmetic treatments. ***Non-emergency transportation services for a companion*** Sun Life will cover the cost of transportation by rail, boat or air, for one companion to travel with a covered person requiring treatment, if: • the attending doctor confirms that a companion is medically required for the covered person requiring treatment, or • the covered person requiring treatment is a dependent child under the age of 18 and the companion is the child's parent. Sun Life will not pay for the costs of: • meals or accommodations expenses. • transportation services relating to any cosmetic treatments

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private duty nurse and services of a personal support worker or similar service	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties For Personal support worker or similar service, a doctor must certify that, because of illness, you are, and will likely continue for a prolonged period of indefinite duration to be, dependent on others for personal needs and care and require full-time support. The personal support worker, or similar service provider, must be at least 18 years of age and cannot be a family member.	Combined $10,000 per person per benefit year Services of a personal support worker or similar service are limited to 4 hours per day per person
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services, including services of an ambulance attendant Must be medically necessary The ambulance attendant must be a registered nurse and cannot be a family member.	For ambulance attendants, $500 per person in a benefit year
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary	

Covered expenses	Details	Payment limits
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor • ultrasounds • medical imaging services, including MRIs and CT scans	For all medical imaging services combined, $1,000 per person per benefit year
Dental services following an accident	Dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered You must receive these services within 12 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the employee lives
Contact lenses or intraocular lenses	After cataract surgery	One lens per eye, per lifetime
Wigs	Required as a result of hair loss due to an underlying pathological condition or its treatment Male pattern baldness is excluded	2 wigs per person per benefit year
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs Electric hospital beds are not covered	For wheelchairs, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses or crutches		
Splints or braces	Must be prescribed by a doctor	
Breast prostheses	Required as a result of surgery	one prosthesis per breast over 2 benefit years
Surgical brassieres	Required as a result of surgery	$250 per person per benefit year and limited to 2 brassieres per person per benefit year
Artificial limbs, including myolectric appliances		one prosthesis and $5,000 per person per limb, per lifetime

Covered expenses	Details	Payment limits
Repairs and adjustments to artificial limbs	When there is a pathological or physiological change	$300 per person per benefit year
Artificial eyes		one prosthesis per eye, per lifetime
Stump socks		5 pairs per person per benefit year
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	$500 per person per benefit year
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	$350 per person per benefit year
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	$500 per person per benefit year
Hearing aids		$600 per ear per person in any 36 month period Repairs are included in this maximum
Oxygen		
Continuous Glucose Monitor (CGM) receivers, transmitters or sensors and blood glucose monitors	For Continuous Glucose Monitor (CGM) receivers, transmitters or sensors: Only for persons diagnosed with Type 1 diabetes You must provide us with a doctor's note confirming the diagnosis	Combined maximum of $2,500 per person per benefit year
Insulin pumps / Infusion pumps	Must be prescribed by a doctor	$800 per person, per lifetime
Insulin pump / Infusion pump supplies		$50 per person per benefit year
TENS machines	Must be prescribed by a doctor	$300 per person over 5 benefit years
Colostomy supplies		
Pressure garments	For burn patients	$500 per person per benefit year

Covered expenses	Details	Payment limits
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary
Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us. *Qualified* paramedical practitioners must: • belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us, • be licensed or registered, as required by the applicable provincial regulatory body, • have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered, • maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association, • produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and • not engage in administrative practices unacceptable to us. This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.		
Visual therapy		Up to the reimbursement level indicated in the Benefit Summary
Vision care		
Contact lenses, eyeglasses or laser eye correction surgery	An ophthalmologist or licensed optometrist must have prescribed contact lenses or eyeglasses You must have received the above from an ophthalmologist, licensed optometrist or optician We will only cover laser eye correction surgery that an ophthalmologist has performed	Up to the reimbursement level indicated in the Benefit Summary A separate maximum applies to contact lenses prescribed for the treatment of severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia, if visual acuity in the better eye cannot be improved to at least 20/40 with eyeglasses We will not pay for sunglasses or magnifying glasses of any kind, unless they are prescription glasses needed for the correction of vision We will not pay for safety glasses of any kind
Ophthalmologist or a licensed optometrist	Services of an ophthalmologist or licensed optometrist	Up to the reimbursement level indicated in the Benefit Summary

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that we consider ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- 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.

Integrating this plan 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 the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

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 and customary charges**. We will not cover more than the fee stated in the Dental Association Fee Guide specified in the Benefit Summary. 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.

Reasonable and customary charges mean:

- charges considered necessary for the treatment and maintenance of a person's oral health, according to standard Canadian dental procedures and practices, and
- charges of a reasonable frequency and duration, as determined by Sun Life.

We will base payments on the fee guide at the time the person receives the treatment.

To decide what part of a procedure we will pay for:

- we will first find out if you could have had alternate, or other, dental procedures.
- we confirm that these alternate procedures are part of usual and accepted dental work and produced a similar result to the procedure that the dentist performed.

We will only pay 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 reasonable and customary charge for the final dental service.
Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. The benefit year is indicated in the Benefit Summary. 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. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary**.
Maximum benefit	Maximums are indicated in the Benefit Summary.

Getting an estimate before you have certain procedures	For any major treatment or any procedure that will cost more than $500, we suggest that you send us an estimate before the work is done. Here's what to expect: • you will 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.

Your dental services at a glance

Covered expenses	Details / Payment limits
Preventive dental procedures – Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs routinely to help maintain good dental health.	
Oral examinations	• 1 complete examination every 36 months. • 1 recall examination every 5 months, up to 2 examinations per benefit year. • emergency or specific examinations.
X-rays	• 1 complete series of x-rays or 1 panorex every 12 months. • 1 set of bitewing x-rays every 5 months, up to 2 sets per benefit year. • x-rays to diagnose a symptom or examine progress of a certain course of treatment.
Other services	• required consultations between two dentists. • polishing (cleaning of teeth) and topical fluoride treatment once every 5 months, up to 2 per benefit year. • scaling, when performed with a recall examination, every 5 months. • emergency or palliative services. • diagnostic tests and laboratory examinations. • removing impacted teeth and related anaesthesia. • providing space maintainers for missing primary teeth. • pit and fissure sealants. • oral hygiene instruction, once in a person's lifetime.
Basic dental procedures – Your dental benefits include the following procedures used to treat basic dental problems.	
Fillings	• amalgam (silver) and composite or acrylic (white), or equivalent.
Extraction of teeth	• removing teeth, except 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	• treating disease of the gum and other supporting tissue. • scaling and root planing, up to a combined maximum of 1 unit of 15 minutes per benefit year for a child under age 13 or 9 units of 15 minutes per benefit year for any other person.

Covered expenses	Details / Payment limits
Oral surgery	• surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*).
Repair of dentures	• repair of dentures, once every 24 months.
Rebase or reline	• rebase or reline of an existing partial or complete denture, once every 24 months.
Mouthguards	• mouthguards, one appliance every 12 months.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

We will not pay for services or supplies that are not usually provided to treat a dental problem.

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstruction (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- transplants and repositioning of the jaw.
- charges related to implants, including surgery charges.
- charges related to the temporomandibular joint (TMJ) treatment.
- experimental treatments.

We will also not pay for dental work resulting from:

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

Life Coverage

Who we will pay	If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. If a dependent dies, we will pay you the benefit for that dependent. For your spouse's optional coverage, we will pay the full amount of the benefit to the last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to you. **Fact** If you designated a beneficiary under a previous group plan of the employer, we will apply and carry it forward to your coverage under this plan until you change it. There are different rules for designating a minor beneficiary, please refer to your contract for specific information.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions.

Converting Life coverage

If your Life coverage or your spouse's Life coverage ends or reduces for any reason other than your request, you or your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

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

The request must be made within 31 days that the Life coverage reduces or ends.

Important
There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your employer for details.

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).

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than one in six Canadians, in over 12,000 corporate, association, affinity and creditor groups across Canada.

Our Core values – integrity, service excellence, customer focus and building value – are at the heart of who we are and how we do business.

Sun Life Financial and its partners have operations in 22 key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
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