

your **group**
benefits

York University

**CUPE 3903 Unit 1, Unit 2, Unit 3, Unit 4
Health and Dental Insurance Plans**

**Contract Number 14098
Effective January 1, 2019**

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General Information

About this booklet

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

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

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

The contract holder, York University, self-insures all benefits. This means York University has the sole legal and financial liability for all benefits and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

Eligibility

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

- you are a permanent full-time employee.
- you are actively working for your employer at least 24 hours a week.

There is no waiting period for your group plan.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working

day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

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

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

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

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

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

Enrolment

You have to enrol to receive coverage. To enrol, you must request

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

When coverage begins

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

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

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

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

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

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

Changes affecting your coverage

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

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

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

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

Updating your records

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

- change of dependents.
- change of name.

When coverage ends

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

- the date your employment ends for any reason other than retirement on pension.
- the date you are no longer actively working.
- the date the benefit provision under which you are covered terminates.

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

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.

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

Making claims

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

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

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

For the assessment of a claim, Sun Life may require medical records or

reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions

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

Coordination of benefits

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

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

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

The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

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

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

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

- the plan where the person is covered as an active part-time employee.
- the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

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

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

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

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

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

Medical examination	We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.
Recovering overpayments	We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.
Definitions	Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.
<i>Accident</i>	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
<i>Classes</i>	<i>Class R</i> – CUPE 3903 Unit 1 <i>Class R1</i> – CUPE 3903 Unit 2 <i>Class R2</i> – CUPE 3903 Unit 3 <i>Class R4</i> – CUPE 3903 Unit 4
<i>Doctor</i>	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
<i>Illness</i>	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.
<i>Retirement date</i>	If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.
<i>We, our and us</i>	We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care (Medicare Supplement)

General description of the coverage

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

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *Medically necessary* means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

An expense must be claimed within 15 months from the date in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

Deductible

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

For prescription drugs there is a deductible of \$3 for each prescription or refill.

For other expenses, there is no deductible.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

If 2 or more members of your family suffer injuries in the same

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accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.

Prescription drugs

After you pay the deductible, we will cover 100% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins, insulin and allergy extracts with a DIN. Syringes for self-administered injections are also covered.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies including syringes, needles, alcohol, swabs, lancets, test strips and Novolin-Pens or similar insulin injection devices using a needle.
- Autolet / Monolet (blood letting device) including platforms.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$500 for each person.
- vaccines used to prevent disease.
- varicose veins medication.
- intrauterine devices (IUDs) and diaphragms.
- oral contraceptives.
- varicose vein injections.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to a maximum of 1 per person over a period of 4 benefit years.

- insulin infusion sets (excluding insulin pumps).

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period as ordered by a doctor.

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

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatment.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- drugs for the treatment of sexual dysfunction.
- drugs for the treatment of infertility.
- colostomy and ileostomy supplies.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

***Other health
professionals allowed
to prescribe drugs***

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

**Paramedical
services**

We will cover 100% of the costs, up to a maximum of \$2,000 per specialty and an overall combined maximum of \$3,000 per person per benefit year for all paramedical specialists listed below:

- licensed psychologists and social workers.
- licensed massage therapists.
- licensed physiotherapists (treatment of movement disorder).
- licensed naturopaths.
- licensed chiropractors (treatment of muscle and bone disorder).
- licensed podiatrists (treatment of foot disorders) or chiropodists.
- licensed psychoanalysts.
- licensed psychotherapists.
- licensed family therapists.
- licensed psychiatrists.

**Contact lenses,
eyeglasses or laser
eye correction
surgery**

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

We will cover 100% of these costs up to a maximum of \$400 in any 24 month period per person.

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.

- When coverage ends** Extended Health Care coverage will end on the earlier of:
- 5 months after your employment contract ends, or
 - the date you are no longer eligible for coverage, and
 - the date the group contract terminates.

Coverage may also end on an earlier date, as specified in *General*

Information.

Payments after coverage ends

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

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

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

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- any services or supplies that are not usually provided to treat an

illness, including experimental or investigational treatments.
Experimental or investigational treatments mean treatments that are not approved by Health Canada or other government regulatory body for the general public.

- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integration with government programs

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

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

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

When and how to make a claim

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

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

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

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Dental Care

**General description
of the coverage**

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

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

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

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

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide approved by the provincial Dental Association for that specialist will be used.

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

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

If you receive any temporary dental service, it will be included as part

of the final dental procedure used to correct the problem and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

An expense must be claimed within 15 months from the date in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure. For procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than \$3,000 per person for each benefit year for all services.

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$500. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Preventive dental procedures

Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

We will pay 100% of the eligible expenses for these procedures.

Oral examinations

1 complete examination every 36 months. A complete examination includes complete examination and charting of the hard and soft structures, periodontal charting, pulp vitality tests, recording history, treatment planning, case presentation and consultation with the patient

1 periodontic examination every 6 months.

1 recall examination every 9 months. Recall and specific examinations

include a complete examination of the hard and soft structures, checking occlusion, pulp vitality tests and consultation with the patient.

You are also covered for emergency or specific examinations:

- an emergency examination includes an evaluation for acute pain or infection, and pulp vitality tests.
- specialty examinations and evaluation of a specific situation.

X-rays 1 complete series of x-rays and 1 panorex every 36 months. A complete series of x-rays (minimum of 16 films including bitewings), showing all the teeth in the mouth. A panorex is a large panoramic view of the entire mouth.

1 set of bitewing x-rays every 9 months. A bitewing x-ray is a routine check-up x-ray used to detect decay in molar teeth.

X-rays to diagnose a symptom or examine progress of a particular course of treatment.

Other services Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment once every 9 months.

Emergency or palliative services.

Test and lab exams Test and lab examinations covered by this benefit include microbiological tests, histological tests and cytological tests.

Extraction of impacted tooth This procedure includes local anaesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation.

Space maintainers and maintenance You are covered for this procedure when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth.

Pit and fissure sealants Once every 60 months. This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming.

Oral hygiene instruction once every 9 months.

Anaesthesia Anaesthesia in conjunction with Preventive procedure covered under this plan.

Basic dental procedures

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

We will pay 100% of the eligible expenses for the following procedures.

Fillings You are covered for amalgam fillings (silver) and composite or acrylic fillings (white fillings) or equivalent.

An amalgam filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on 1 surface will be considered a single filling.

A composite or acrylic filling procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on 1 surface will be considered a single filling. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

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

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

Scaling and root planing **Tartar removal.** Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits. You are covered for up to a combined maximum of 16 units of 15 minutes in any 12 month period.

Occlusal equilibration You are covered for treatments to adjust your bite, up to a maximum of 8 units of 15 minutes in any 12 month period. This treatment is only available when you have gum surgery or temporomandibular joint (TMJ) treatment.

Oral surgery Surgery, other than the removal of impacted teeth (*Preventive dental procedures*) and implant related surgery (*Major dental procedures*). Oral surgery includes local anaesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation.

Repair Repair of dentures, once every 36 months. Repairing dentures means fixing broken or damaged dentures.

Rebase or reline Rebase or reline of an existing partial or complete denture, once every 36 months.

Relining dentures means adding material so that the dentures fit properly. Rebasing dentures means fitting dentures with a new base.

We will pay 100% of the eligible expenses for the following procedures.

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

Root canal therapy. This procedure includes treatment plan, pulp vitality test, opening and drainage, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, relieving occlusion, smoothing tooth, and follow-up care. If root canal therapy is performed on the same tooth by the same dentist within 3 months of opening and drainage, pulpotomy or pulpectomy, the amount payable is reduced by the amount previously paid for such opening and drainage, pulpotomy or pulpectomy.

Apexification. This procedure includes treatment plan, local anaesthesia, tooth isolation, clinical procedure with appropriate x-rays, placement of dentogenic media, and follow-up care. You are only covered for permanent teeth.

Apicoectomy. This procedure includes treatment plan, local anaesthesia, clinical procedure with appropriate x-rays, root resection, apical curettage, and follow-up care.

Retrofilling. This procedure includes apicoectomy, curettage and root-end filling.

Root amputation. This procedure includes recontouring tooth and furca.

Hemisection. You are covered for this procedure.

Vital pulpotomy. This procedure includes treatment plan, local anaesthesia, clinical procedure and appropriate x-rays, and follow-up care.

We will pay 50% of the eligible expenses for the following procedures.

Prosthodontic examinations.

Diagnostic casts.

Hemisection.

Periodontics We will pay 80% of the eligible expenses for treatment of disease of the gum and other supporting tissue.

Anaesthesia Anaesthesia in conjunction with Basic procedure covered under this plan.

Major dental procedures

Your dental benefits include the following procedures used to treat major dental problems.

We will pay 85% of the eligible expenses for these procedures.

Inlays and onlays Inlays and onlays are metal or porcelain fillings placed on the surface of the tooth. Inlays and onlays are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

Inlays and onlays include treatment planning, occlusal records, local anaesthesia, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. Inlays are only covered when x-rays indicate a crown will be required. Onlays are limited to teeth with extensive incisal or cusp damage.

Crowns This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. It includes porcelain crowns for molar teeth. Crowns are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

Repair Repair of bridges.

Prosthodontics Construction and insertion of bridges or standard dentures. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

- it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.
- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Implants Implants, including surgery charges. Charges for a replacement implant is not considered an eligible expense during the 5 year period following the insertion of a previous implant. The maximum amount payable is \$1,000 per person per benefit year. This is included in the overall benefit year maximum of \$3,000.

Anaesthesia Anaesthesia in conjunction with Major procedure covered under this plan.

- When coverage ends** Dental Care coverage will end on the earlier of:
- 5 months after your employment contract ends, or
 - the date you are no longer eligible for coverage, and
 - the date the group contract terminates.

Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition

(worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).

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

We will also not pay for dental work resulting from:

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

When and how to make a claim

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

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

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

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

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

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