McMaster University

Retired Faculty
Plan 4

Contract Number 25018 and 50813
Effective October 1, 2003

McMaster University is pleased to provide our retired Faculty members with a comprehensive outline of the Extended Health, Dental, and Group Life benefit plans. These plans apply to individuals who retired after July 1, 1998 or those who retired earlier and opt to participate in this plan.

McMaster University provides you with the Extended Health, Dental, and Group Life as part of the many valuable benefits available to you upon retirement. This booklet is supplied by Sun Life and contains detailed coverage information of the benefits provided through Sun Life.

The Extended Health benefit is provided in combination with the provincial health plan, in order to protect both you and your eligible dependents against the cost of a wide range of medically necessary services and supplies. To be eligible for coverage under the Extended Health plan with Sun Life you must be covered under your provincial health plan. For further information on your provincial health care coverage, please contact your local provincial health care office.

Should you have any questions regarding your benefit coverage, please contact the Retirement Support Services Unit of Human Resources at McMaster University at 905-525-9140 extension 24570 or 23692 or pension@mcmaster.ca. Alternatively, information regarding your benefits and claim procedures can also be obtained by visiting our website at www.workingatmcmaster.ca.

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General Information

The information contained in this section applies only to benefits for which Sun Life of Canada is the plan administrator.

About this booklet

The information in this retiree benefits booklet is important to you. It provides the information you need about the group benefits available through McMaster's group plan with Sun Life.

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 retiree benefits booklet, or you need additional information about your group benefits, please contact McMaster University.

The contract holder, McMaster University, has the sole legal and financial liability for the following benefits:

- Extended Health Care
- Dental Care

Sun Life only acts as administrator on behalf of the contract holder for the above benefits.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and must have been enrolled in the group benefit plan immediately prior to your retirement.

To be eligible for coverage under the Extended Health plan with Sun Life you must be covered under your provincial health plan. For further information on your provincial health care coverage, please contact your local provincial health care office.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada and listed as a dependent at the time of retirement.

To be eligible, your spouse must be legally married to you, or be your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, provided that you are not legally married. You can only cover one spouse at a time. Coverage is extended only to the person legally represented as your spouse at the time of retirement.

Your children and your spouse's children (other than foster children) are eligible dependents:

- who are unmarried and under age 21.
- for whom you have actual custody or legal financial responsibility.
- who are listed as a dependent at the time of retirement.

A child who is a full-time student attending an educational institution recognized by Canada Customs and Revenue Agency is also considered an eligible dependent until the age of 25 as long as the child is entirely dependent on you for financial support and you have actual custody or legal financial responsibility.

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 remains unmarried.

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

Enrolment

You have to enrol to receive coverage. To enrol, contact McMaster University to complete the necessary enrolment forms. You must also

enrol your eligible dependents in order for them to receive coverage.

Proof of good health will be required when you request Optional Life coverage and any increase in that coverage. Coverage will not take effect before Sun Life approves the proof of good health.

Please see McMaster University for the appropriate enrolment forms.

When coverage begins

Your coverage begins on the date you retire. If you have single coverage at the time of retirement, you cannot convert to family (dependent) coverage at a later date.

For a dependent, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

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, McMaster may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to Retirement Support Services at McMaster University:

- in the event your spouse dies or you are no longer married.
- change of name.
- change of beneficiary.
- overage students.
- change of address.

When coverage ends

As a retiree, your coverage will end on the earlier of the following dates:

- the date the benefit provision under which you are covered terminates.
- the date the group contract ends.

However, if you die while covered by this plan, coverage for your dependents will continue until the earlier of the following dates:

- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is 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 retiree benefits booklet.

Replacement coverage

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

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

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact Retirement Support Services at McMaster University 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 retiree benefits booklet. All claims must be

made in writing on forms approved by Sun Life.

Claims services

The following services have been set up to assist you in better understanding your Benefit Programs. You may direct your questions, comments or concerns to McMaster's Retirement Support Services or Sun Life.

If you have a question concerning a specific medical or dental claim, you should call Sun Life. Their telephone number is 1-800-361-6212. Your name, policy # (25018) and certificate number (retiree I.D. #), which are shown on your Sun Life card should be provided. You may also e-mail Sun Life at askus@sunlife.com. In addition to the above information, you should include your spouse or dependent's name, type of claim and your phone number. If the question is about a claim that has already been paid or declined, provide the "claim" or "control" number located on your Explanation of Benefits (EOB).

If you have a question concerning your coverage for Life, please contact Retirement Support Services at McMaster University.

If you need forms for claims or to make positive enrolment changes please contact Retirement Support Services at McMaster University or access the forms on line at www.workingatmcmaster.ca.

All eligibility issues are between you and the University. Sun Life pays claims based on information you provide to the University. If claims are submitted and you have not enrolled your dependents, they will not be covered. Only expenses incurred after the date of enrolment can be honored. If a problem arises, call Retirement Support Services at McMaster University.

All questions regarding what constitutes reasonable and necessary expenses are determined by the insurer in accordance with our contract and common practices within the insurance industry for policies of this type. Where you have questions that concern a particular treatment, or plan of treatment, you should contact Sun Life.

Coordination of benefits

If you 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 where you should send a claim first. Here are some guidelines:

- if you are claiming expenses for your spouse and the spouse is covered for those expenses under another plan, you must send the claim to your spouse's plan first.
- if you are claiming expenses for your children, and both you and your spouse have coverage under different plans, you must claim under the plan of the parent with the earlier birthday (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

McMaster University can help you determine which plan you should claim from first.

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 retiree benefits booklet. Other definitions appear in the benefit sections.

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

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

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

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

Extended Health Care
(Medicare Supplement)

Plan administrator

This benefit is administered by Sun Life of Canada.

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 retiree 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.

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

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

The benefit year is from July 1 to June 30.

Deductible

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

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

Prescription drugs

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

For the following expenses you should use your drug card:

- medication listed in the Federal or Provincial Drug Schedules

which has a Drug Identification Number (DIN) and requires a prescription.

- injectable drugs and vitamins, insulin and allergy extracts with a DIN.
- preparations and compounds of which at least one ingredient is an eligible drug under this benefit.
- diabetic supplies.
- drugs for the treatment of infertility up to a lifetime maximum of $2,400 for each person.
- drugs for the treatment of erectile dysfunction, up to a maximum of $1,200 per person in a benefit year.
- Xenical for the treatment of weight loss.

For the following expenses you must submit a claim to Sun Life for reimbursement:

- vaccines and compound serums that require a prescription.
- intrauterine devices (IUDs).
- colostomy supplies.
- varicose vein injections, if medically necessary.

We will cover the cost of the above medicines and supplies after you pay the deductible.

For prescription drugs the deductible is the portion of any dispensing fee over $6.50 for each prescription or refill.

For the above items, payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period, or, in the case of the following maintenance drugs, in a 100 day period as ordered by a doctor:

antiasthmatics, antibiotics for acne, anticoagulants, anticonvulsants, antihypertensives, antiparkinsons, antituberculosis, cardiac agents, hypoglycaemics, medications for glaucoma, oestrogens, oral contraceptives, potassium replacements and thyroid agents.

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.
- medicines obtained from a doctor or dentist.
- treatments for weight loss, including drugs, proteins and food or dietary supplements, except as noted above.
- muscle relaxants which do not require a prescription.
- hair growth stimulants.
- products to help you quit smoking, whether or not they require a prescription.

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.

Hospital expenses in your province

We will cover 100% of the Plan maximum for hospital care in the province where you live.

We will cover out-patient services in a hospital, and the difference between the cost of a ward and a semi-private hospital room up to a maximum of $110 per day.

Where the cost of the room exceeds this $110 per day limit, and where the out-of-pocket cost for the hospital room exceeds $300 per person per benefit year, your out-of-pocket eligible expenses beyond $300 will be reimbursed.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as:

- it follows at least 5 consecutive days of in-patient hospitalization,
- it begins within 14 days of release from the hospital, and
- it is primarily for rehabilitation.

We will also cover the cost of confinement in a rehabilitation centre which is operated by the province of Ontario for treatment of drug addiction or alcoholism, provided the cost has been approved in writing by Sun Life.

The maximum amount payable for convalescent hospital or for a rehabilitation centre is $20 per day up to a maximum of 120 days in a benefit year.

For purposes of this plan, 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.

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.

Retirees living outside of Ontario but within Canada

Medical benefits are continued regardless of where you choose to reside within Canada.

It should be noted, however, that Sun Life will not reimburse expenses which they would not have paid had you continued to reside in Ontario.

For instance, any prescribed drugs that would have been paid by the Ontario provincial health insurance plan for an individual over age 65 would not be reimbursed under our plan.

With regard to the "out of province" coverage, you are provided with coverage of $10,000 (lifetime maximum) for emergency services outside your place of residence.

For instance if you live in Alberta, that would be your place of residence.

You must pay for services first, and then submit claims to Sun Life who will deduct the amount that the Ontario health insurance plan would have paid had you been a resident of Ontario and then pay up to the reasonable and customary rates for the region where the services were provided.

It should be noted that you should submit all bills since those items covered do change and no comprehensive list exists at any one time which could assist you.

Claims not submitted in English may cause problems which will lead to difficulty in payment of the claims. It is recommended that you take extra care in having your doctors and dentists clearly describe the treatments to enable the insurance company to properly adjudicate your claims.

Expenses out of your province

We will cover emergency medical services while you are outside the province where you live. We will also cover referred services.

An *emergency* is an acute, unexpected condition, illness, disease or injury that requires immediate assistance. We will pay 100% of the cost of qualified emergency services up to a lifetime maximum of $10,000.

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

For both emergency services and referred services, we will cover the

cost of:

- a semi-private hospital room up to a maximum of $110 per day.
- hospital services, other than room and board, provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

All referred services must be:

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

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

We will only cover services obtained within 60 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services out of your province

Expenses incurred for emergency services outside the province where you live are subject to a lifetime maximum of $10,000 per person or, if lower, any other applicable lifetime maximum.

Private duty nurse services

We will cover out-of-hospital private duty nurse services when medically necessary and when ordered by a doctor. Services must be for nursing care, and not for custodial care. 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 can not perform the duties.

We will cover 40% of the first $25,000 of eligible expenses (equals $10,000) and where eligible expenses exceed $25,000, we will pay 80% of the next $25,000 (equals $20,000) of eligible expenses per person. Each benefit year after a claim has been paid, 1/2 of the amount

utilized will be reinstated. After 2 benefit years with no claims, entitlement is returned to full coverage.

Ambulance services

We will cover 100% of the costs for the ambulance services listed below when ordered by a doctor.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.

Tests and services

We will cover 100% of the costs for the medical services listed below when ordered by a doctor.

- laboratory tests performed by a commercial laboratory for the diagnosis of an illness. Tests performed in a doctor's office or pharmacy are not covered.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- intravenous pumps.

Assistive medical devices guidelines/overview

All benefits payable under the provincial assistance devices program, or by any other group program or community organization should be claimed first.

Equipment must be ordered by a doctor as necessary for a medical condition.

The plan is intended to reimburse individuals for devices purchased that are considered reasonable and customary services or for expenses in the treatment of the illness or injury.

Devices necessary for sports and recreation are not covered.

The plan is limited to the purchase of one device for the intended purpose in any year and is not generally liable for lost or damaged devices, nor repair or maintenance of such devices, unless otherwise noted.

Devices may be replaced when the normal lifetime of such devices has expired.

All amounts eligible under the plan are based on expenses beyond those payments from other sources unless otherwise noted.

Hearing aids

We will cover 75% of the costs of hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per person over a period of 3 benefit years. Repairs are included in this maximum. In those cases where hearing aids for both ears are prescribed, the claimant may receive reimbursement for the second hearing aid under the same conditions.

We will also cover 100% of the costs of the initial purchase of a hearing aid prescribed by an ear, nose and throat specialist, if required as the result of an accident.

Orthotics and orthopaedic shoes

We will cover 80% of the costs of custom-made orthotic inserts for shoes and custom-made orthopaedic shoes or modifications to orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of $400 per person over a period of 2 benefit years.

General medical devices

After you pay the deductible of $50 per person each benefit year, we will cover 75% of the next $400 of eligible expenses and 100% of the remainder of expenses per person in a benefit year for each category of medical services listed below when ordered by a doctor (For any rental, the deductible applies only in the first year.):

- home care devices required to care for the infirmed outside hospital, excluding costs of any home or other renovations. These include, but are not limited to, hospital beds, bath lifts, commodes eggcrate/gel mattresses and hospital beds which are rented, or purchased when ordered by a doctor.

- mobility devices required to allow increased mobility in and outside the house if medically appropriate. These include, but are not limited to, wheelchair lifts, scooters, rollabout chairs, walkers, casts, splints, canes, crutches and wheelchairs which are rented, or purchased when ordered by a doctor. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair. Wheelchair pads and inserts required for use with a chair are also covered.

- braces or trusses required to minimize pain or support part of the body in an appropriate position. These include, but are not limited to, leg or knee braces.

- prosthetics required to replace parts of the body lost due to illness, injury, surgery or malformation at birth or during development. These include, but are not limited to, the purchase and repairs to artificial eyes, legs, arms, breast prosthetics and chin reconstruction. Myoelectric appliances are excluded. We will also cover wigs following chemotherapy or if hair loss is due to a disease, up to a lifetime maximum of $500 per person. Wigs do not require a doctor's order.

Other medical services and equipment

We will also cover 100% of the costs for the medical services listed below when ordered by a doctor.

- 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. These services must be received within 6 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the retiree lives. The guide must be the current guide at the time that treatment is received. Expenses incurred outside your province of residence for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- elastic support stockings, including pressure gradient hose.

- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- surgical brassieres required as a result of surgery.

Paramedical services

We will cover 100% of the costs for the paramedical specialists listed below:

- licensed speech therapists, up to a maximum of $200 per person in a benefit year
- licensed psychologists, when ordered by a doctor – $15 per half hour for the initial visit and $15 per visit for subsequent visits, up to a maximum of $225 per person per benefit year.
- licensed physiotherapists – $15 per visit, up to a maximum of $225 per person per benefit year.
- licensed massage therapists, when ordered by a doctor – $15 per visit, up to a maximum of $225 per person per benefit year.
- licensed osteopaths, chiropractors, podiatrists or chiropodists – $15 per visit, up to a maximum of $225 per person per benefit year per practitioner. Also included is one x-ray examination per specialty each benefit year.
- licensed naturopaths – $15 per visit, up to a maximum of $225 per person per benefit year.
- licensed Christian Science Practitioner – $15 per visit, up to a maximum of $225 per person per benefit year.

Contact lenses, eyeglasses or laser eye correction surgery (for the retiree only)

We will cover the cost of contact lenses, eyeglasses 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 $150 per retiree for one purchase every 24 months. If a period of three years

passes between any claim for vision care, we will provide a maximum of up to $200 towards the purchase. No coverage exists for dependents.

We will also cover 100% of the costs for the initial purchase of prescription glasses if required as the result of an accident when prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician.

We will not pay for sunglasses, magnifying glasses, safety glasses or for repairs to eyeglass frames of any kind.

What is not covered

We will not pay for the costs of:

- services or supplies payable in whole or in part under any government-sponsored plan or program, except for user fees, extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- 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.

When and how to make a claim

To make a claim, complete the claim form that is available from Retirement Support Services.

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

- prior to September 30th following the end of the benefit year (July 1 to June 30) in which the claims were incurred, or
- the end of your Extended Health Care coverage.

Dental Care

Plan administrator

This benefit is administered by Sun Life of Canada.

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 retiree 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 of the province of Ontario, 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 speciality, then 120% of the fee guide approved by the Ontario 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.

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

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

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

The benefit year is from July 1 to June 30.

Deductible

There is no deductible for this coverage.

Emergency expenses out of your province of residence

Expenses incurred for emergency dental services out of your province of residence are eligible if:

- they represent the usual, customary and reasonable charges for the procedures in the locality where they are performed, and
- charges for such procedures would be paid under this policy had the procedures been performed in your province of residence, or if you do not reside in Canada, in the province of the place of issue.

For expenses incurred for other than emergency dental services out of your province of residence, but within Canada, we will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners of the province of Ontario, regardless of where the treatment is received.

Predetermination

We suggest that you send Sun Life an estimate, before the work is done, for any major treatment or any procedure that will cost more than $500. You should send Sun Life 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. Sun Life 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 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 48 months.

1 recall examination, limited to one examination every 6 months for children under 14 or every 9 months for any other person.

Emergency or specific examinations.

X-rays

1 complete series of x-rays or 1 panorex every 48 months.

1 set of bitewing x-rays every 9 months.

Periapical radiographs.

Interpretation of radiographs received from another source.

Cephalometric radiographs.

Occlusal films.

Extra oral films.

Sinus examination.

Sialography.

Use of radiopaque dyes to demonstrate lesions.

Temporomandibular joint films - minimum four films.

Duplicate radiographs.

Tomography.

Hand and Wrist (as diagnostic aid for dental treatment).

Tests and laboratory examination.

Other services Polishing (cleaning of teeth) and topical fluoride treatment, limited to one treatment every 6 months for children under 15 or every 9 months for any other person.

Emergency or palliative services.

Provision of space maintainers for missing primary teeth.

Pit and fissure sealants, but not more than once to the biting surface of the first permanent molar teeth for children under 9 or once to the biting surface of the second permanent molar teeth for children under 15, limited to once per tooth per person's lifetime.

Oral hygiene instruction.

Nutritional counselling.

Finishing restorations, including removal of overhangs, refining of marginal ridges and occular surfaces when restorations were performed by another dentist or restorations are more than two years old.

Mouthguards (other than those intended for sport use).

Basic dental procedures

Your dental benefits include procedures used to treat basic dental problems. Some examples are filling cavities and extracting teeth.

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

Fillings Amalgam, composite, acrylic or equivalent.

Extraction of teeth Removal of teeth.

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

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

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

Oral surgery Surgery and related anaesthesia.

Rebase or reline Rebase or reline of an existing partial or complete denture.

Other services Professional consultation.

Major dental procedures

Your dental benefits include procedures used to treat major dental problems. Some examples are crowns, dentures or bridges.

We will pay 70% of the eligible expenses for these procedures, up to a maximum of $2,000 per person for each benefit year.

Major restorations Inlays and onlays. Crowns and repairs to crowns, other than prefabricated metal restorations (*Please see the Basic Dental Procedures section for prefabricated metal restorations coverage*).

Repair Repair of bridges or dentures.

Prosthodontics Construction and insertion of bridges or standard dentures, after the person has been covered continuously under this provision for a period of 12 months. 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.

Orthodontic procedures

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Your dental benefits include procedures used to treat misaligned or crooked teeth.

We will pay 50% of the eligible expenses for these procedures, up to a maximum amount of $2,000 in a covered person's lifetime.

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

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Please see the Preventive dental procedures section for space maintainers*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

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 in whole or in part under any government-sponsored plan or program, except for user fees, extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.

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).
- implants and transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

To make a claim, complete the claim form that is available from McMaster University. The dentist will have to complete a section of the form. Claims may be submitted electronically for some expenses. Please contact Retirement Support Services for more information.

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

- prior to September 30th following the end of the benefit year (July 1 to June 30) in which the claims were incurred, or
- the end of your Dental Care coverage.

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

Life Coverage

General description of the Life coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

Life coverage for you

Amount

Your Life benefit is $5,000.

If you retire on or after July 1, 1997, you may elect at retirement to retain your Basic Life coverage in force immediately prior to retirement until age 65.

On the first of the month coincident with or next following the date you reach age 65, coverage will reduce to $5,000.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid 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.

Converting Life coverage

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

Written application must be made to Sun Life, accompanied by the first premium no later than 31 days after coverage ends or is reduced. This is called the 31 day conversion period.

You may choose an individual plan with equivalent coverage to the coverage which terminated or reduced under your plan, but without disability benefits. If equivalent coverage is not provided under an

individual plan issued by Sun Life, then Sun Life will offer a plan of equal value. You may instead choose any other individual policy which Sun Life is willing to offer, but without disability benefits.

The amount of individual life insurance will be limited by the following:

- if coverage is terminated or reduced because the group contract is terminated or amended, the amount of a person's individual life insurance policy may not exceed the amount of coverage that is terminated or reduced less any amount of insurance available under another group contract within 31 days.
- if coverage is terminated or reduced for any other reason, the amount may not exceed the amount of coverage that was terminated or reduced.
- if a person is entitled to convert coverage under more than one benefit provision or more than one contract issued by Sun Life to the contract holder, then the sum of the amounts available for conversion under all such benefit provisions or contracts will be pro-rated over the various benefit provisions or contracts based on the amount of coverage in force when coverage was terminated or reduced.
- in all cases, the amount of the individual life insurance policy cannot exceed $200,000.
- if a person does not convert the entire amount available for conversion, the individual life insurance cannot be less than the minimum amount which Sun Life issues for the plan selected.
- the premium rate for the individual policy will be based on Sun Life's rate for the sex, plan and age of the person on the effective date of the individual policy. If requested and the person applying for the insurance is under age 66, the premium rate for the first year will be that of a one year term policy, but the premium rates after the first year will be based on the original age plus one. If any portion of the converted group coverage was based on a rating under this contract, Sun Life will apply the same rating when determining the premiums for such portion of the individual policy.
- the effective date of the individual policy will be the day following the end of the 31 day conversion period.
- if, after the conversion, a person is insured within 6 months under any Sun Life group contract with the contract holder, the amount of

coverage under the group contract will be limited to the amount of the person's coverage under the group contract minus any amount still in effect under the individual life insurance policy.

31 Day Free Cover:

When Sun Life receives proof of claim that a person has died during the 31 day conversion period, Sun Life will pay the amount of coverage eligible for conversion.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from Retirement Support Services at McMaster University.

Respecting Your Privacy

Within the Sun Life Financial group of companies, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with insurance and investment products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees and representatives who are responsible for the administration and servicing of your contract(s) with us, or any other person whom you authorize. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our Web site at www.sunlife.ca or call 1 800 361-2128 and request that a copy of our Privacy Brochure be sent to you.