

your **group**
benefits

McMaster University

**CUPE Local 3906, Unit 3: Postdoctoral
Fellows with Grandparented Sun Life Dental**

**Contract Number 25018, 50813 & 30066
Effective July 1, 2008**

The Worldwide Travel Benefits is insured by Medavie Blue Cross

McMaster University provides you with the Extended Health, Dental and Worldwide Travel Assistance group plans as a benefit of your employment, the details of which are outlined in this booklet.

You must be enrolled in the Extended Health plan in order to be eligible to participate in the Worldwide Travel Assistance benefit. The Extended Health benefit is provided in combination with the provincial health plan, in order to protect both you and your dependents against the cost of a wide range of medically necessary services and supplies. To be eligible for coverage under the Extended Health and Dental plans with Sun Life, you and your dependents must be covered under the provincial health plan (or University Health Insurance Plan or University Health Insurance Plan Exempt). For further information on your provincial health care coverage, please contact your local provincial health care office.

This booklet is supplied by Sun Life, and contains detailed coverage information for the benefits provided through them. The Worldwide Travel Assistance benefit is provided through Medavie Blue Cross and details of this plan's coverage are also included in this booklet.

Should you have any questions regarding your benefit coverage, please contact Sun Life directly at 1-800-361-6212. Alternatively, you may contact the Human Resources Services office at McMaster University by email at working@mcmaster.ca for information regarding your benefits and claim procedures.

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General Information

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

About this booklet

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

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

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

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.
- be enrolled in provincial health care (or University Health Insurance Plan or University Health Insurance Plan Exempt)

- hold a postdoctoral fellow appointment at McMaster for a minimum duration of twelve months or more.

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 scheduled period of paid vacation 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 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 enrol 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 and maintaining provincial health coverage (or University Health Insurance Plan coverage).

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 has been publicly represented as your spouse for at least the last 12 months, 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:

- who are unmarried and under age 21.
- for whom you have actual custody or legal financial responsibility.

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 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 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.

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 your employer for the appropriate enrolment forms.

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

Updating your records

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

- change of dependents.
- change of name.
- change of beneficiary.
- coverage students.
- change of address.

When coverage ends

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

- the date your employment ends.
- the date you are no longer actively working.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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

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

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

Replacement coverage

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

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

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

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your employer to get the proper form to make a claim. There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. All claims must be made in writing on forms approved by Sun Life.

No legal action may be brought by you more than one year after the date we must receive your claim forms or more than one year after we

stop paying disability benefits.

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 via email at working@mcmaster.ca to the Human Resources Services at McMaster University.

If you have a question concerning a specific medical or dental claim, please call Sun Life at 1-800-361-6212. Your name, policy number (25018) and certificate number (employee I.D. number), 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, please include your spouse or dependents' name as applicable, 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 coverages for Life or the Worldwide Travel benefit, please contact your Area Human Resources Office.

If you need forms for claims or to make positive enrolment changes please contact your Area Human Resources Office 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 honoured. If a problem arises, call your Area Human Resources Office.

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.

Proof of disability

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 the request, you will not be entitled to benefits.

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.

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 excluding any bonus or overtime pay.

If you are on a pre-retirement reduced work load, basic earnings will be based on your full-time earnings as defined above.

If you are on a general reduced work load, basic earnings will be prorated according to your reduced earnings for the duration of your participation in the reduced workload program.

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

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

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

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

Extended Health Care (Medicare Supplement)

Plan administrator	<i>This benefit is administered by Sun Life of Canada.</i>
General description of the coverage	<p>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.</p> <p>In this section, <i>you</i> means the employee and all dependents covered for Extended Health Care benefits.</p> <p>Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. <i>Medically necessary</i> 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.</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>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.</p> <p>The benefit year is from July 1 to June 30.</p>
Deductible	<p>The deductible is the portion of claims that you are responsible for paying.</p> <p>After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.</p>
Prescription drugs	<p>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.</p>

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 costs for out-patient services in a hospital in the province where you live.

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 is primarily for rehabilitation, and not for custodial care.

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.

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.

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.

**Expenses for
referred services out
of your province**

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.

We will cover the cost of:

- 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.

Expenses incurred for referred 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 cannot 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.

- the following diagnostic services rendered out of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
 - laboratory tests.
 - ultrasounds.
- 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 or 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 medically necessary and are rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least

expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost 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. 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 12 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 employee lives. The guide must be the current guide at the time that treatment is received.
- 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 – \$15 per half hour for the initial visit and \$15 per visit for subsequent visits, up to a maximum of \$300 per person per benefit year.
- licensed physiotherapists – \$15 per visit, up to a maximum of \$300 per person per benefit year.
- licensed massage therapists, when ordered by a doctor – \$15 per visit, up to a maximum of \$300 per person per benefit year.
- licensed osteopaths, chiropractors, podiatrists or chiropodists – \$15 per visit, up to a maximum of \$300 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 \$300 per person per benefit year.
- licensed Christian Science Practitioner – \$15 per visit, up to a maximum of \$300 per person per benefit year.

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

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 \$250 per employee for one purchase every 24 months.

We will also cover 100% of the following costs:

- 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.

- lenses required as a result of cataract surgery, up to a maximum of \$250 per eye.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind.

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 unless explicitly listed as covered under this benefit.
- 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.

**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 at the earlier of:

- prior to September 30th following the end of the benefit year 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 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 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 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.

For an implant related crown or prosthesis, we will pay the benefit that

would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. We will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

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.

Expenses out of your province of residence

For expenses incurred for non-emergency dental services out of your province of residence, 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 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 48 months.
- 1 recall examination, limited to one examination every 6 months for children under 15 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. Only children under 18 are covered for this treatment. A child is covered for 1 treatment per permanent tooth.

Oral hygiene instruction.

Nutritional counselling.

Finishing restorations, including removal of overhangs, refining of marginal ridges and ocular 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 the following procedures used to treat basic dental problems.

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 the following procedures used to treat major dental problems.

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

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 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.
- 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.
- 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. Claims may be submitted electronically for some expenses. Please contact your employer 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 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

Note: The Group Life Insurance Plan as outlined below applies to employees hired by McMaster University since January 1, 1996 or to those hired prior to this date who opted to participate in this plan. The Basic Group Life Insurance plan is provided as a benefit of your employment. Employees may choose to participate in Optional Group Life Insurance plan, and are responsible for the cost of this benefit. The premiums are payable through monthly payroll deductions.

The “old” or “grand-fathered” Group Life Insurance Plans (entered into prior to January 1, 1996) are **not** described in this booklet. For further information please contact Human Resources at 905-525-9140 ext. 23743 or email working@mcmaster.ca.

Insurer *This benefit is insured by Sun Life Assurance Company of Canada under contract number issued to Council of Ontario Universities.*

General description of the Life coverage Your Life coverage provides a benefit for your beneficiary if you die while covered.

Basic Life coverage for you

Amount Your Life benefit is an amount equal to your annual basic earnings, rounded to the next higher \$1,000 (if not already a multiple of \$1,000), subject to the maximum insurable annual basic earnings of \$100,000 multiplied by 175% subject to the maximum benefit of \$175,000.

Coverage ends Your coverage will end on the last day of the month in which you retire or December 1st of the year you reach age 69, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

If you retire prior to the normal retirement age of 65, you may be eligible to continue a portion of your life coverage. Please contact your

area Human Resources office to confirm your eligibility.

Optional Life coverage for you

You must pay the cost of this coverage. Optional life rates are subject to change. Please see your Area Human Resources Office for current rates.

Amount Your Optional Life benefit is an amount equal to your annual basic earnings, rounded to the next higher \$1,000 (if not already a multiple of \$1,000), subject to the maximum insurable annual basic earnings of \$100,000 multiplied by increments of 25% up to 500% inclusive subject to the maximum benefit of \$500,000.

Proof of good health Required on all optional amounts of coverage.

Coverage ends Your coverage will end on the last day of the month in which you retire or December 1st of the year you reach age 69, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

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.

Coverage during total disability (Optional Only)

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 12 months of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life

coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for at least an uninterrupted period of 6 months.

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

For the purposes of your Life coverage, you will be considered totally disabled if you are prevented by illness from performing any occupation you are or may become reasonably qualified for by education, training or experience.

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 your employer.

Worldwide Travel Benefits

Insurer	<i>This benefit is insured by Medavie Blue Cross.</i>
Eligibility Period	Coverage commences immediately upon employment. <ul style="list-style-type: none">■ benefits are provided for a maximum of 60 days per visit, subject to a lifetime maximum of \$1,000,000 for an accident or unexpected illness outside the province of residence■ payment assistance through CanAssistance■ program pays 100% of the eligible expense
Termination	Benefits provided by this contract terminate at the earlier of retirement, termination of employment, or on December 1 st of the year they attain age 69.

Please refer to the appropriate page in this booklet for a more detailed benefit description

GENERAL INFORMATION

Eligible Employees	<p>You are eligible to enrol for benefits if you are eligible for McMaster's Extended Health Program.</p> <p>Employees may elect coverage, within the 31 days of becoming eligible, by completing an application. Coverage is effective on the date of eligibility, except when: (a) the employee is not actively at work on the day that coverage would otherwise become effective, or (b) the application is made after the 31 day period.</p> <p>If not actively at work when you would normally have become eligible, your coverage will commence when you return to work on a full-time basis.</p>
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Eligible Dependents Dependents are defined as your legal spouse (as described below), and unmarried, unemployed dependent children including natural, adopted or step-children. Children of a common-law spouse may be covered if they are living with the employee.

The term "spouse" is defined as the person who is legally married to the employee; or, although not legally married to the employee, has continuously cohabited with the employee for not less than one full year (common-law). Unless the covered employee has requested coverage for a common-law spouse in writing to Medavie Blue Cross, the person legally married to the insured employee shall be considered to be the spouse.

Unmarried, unemployed children over 25 years of age qualify if they are dependent upon the covered employee by reason of a mental or physical disability and have been continuously so disabled since the age of 25.

Dependent coverage begins for your eligible dependents on the same date as your coverage, or as soon as they become eligible dependents if added later, provided that dependent benefits were applied for within 31 days of their becoming eligible. If coverage is not applied for within this 31 day period, evidence of health on the dependents may have to be submitted and approved before coverage begins.

Evidence of Health Proof of good health is not required if application is made within 31 days of first becoming eligible. If coverage is not applied for within this 31 day period, evidence may be requested for the employee and his dependents, if any, before benefits commence.

Termination of Benefits Coverage for you and your dependents will cease on the earliest of:

- the date you terminate employment.
- the date you cease to be eligible due to retirement, death, leave of absence, age limitation, change in classification, etc.
- the termination date of the Group Contract.

WORLDWIDE TRAVEL BENEFITS

The Group Travel Plan covers a wide range of benefits which may be a result of an accident or unexpected illness incurred outside the Participant's province of residence while on business or vacation. Subject to the maximum amounts indicated below, the Plan pays 100% of the eligible expense with no overall maximum, less the amount allowed under any Government Health Program.

Eligible expenses include:

HOSPITAL ACCOMMODATION - the cost of hospital room accommodation (not a suite) and medically necessary inpatient/outpatient services.

PHYSICIANS AND SURGEONS - customary charges by physicians and surgeons for services rendered.

MEDICAL APPLIANCES - the cost of casts, crutches, canes, slings, splints, trusses, braces and/or temporary rental of a wheelchair, when required due to an accident or sudden illness which occurs outside the province of residence and when ordered by a physician.

NURSE - charges for private duty nursing, including Registered Nurse, Registered Nursing Assistant or Certified Nursing Assistant (not a relative of the patient or an employee of the hospital) when ordered by an attending physician.

AMBULANCE - normal charges for ambulance service, including air ambulance and evacuation to and from the nearest qualified medical facility. Air evacuation between hospitals must receive prior approval of CanAssistance.

REPATRIATION - extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, the benefit covers:

- two economy seats by most direct route to the patient's home city in Canada, one for the covered patient and one round trip fare for a medical attendant;

- the number of economy seats required to accommodate the covered person if on a stretcher and one round trip fare for a medical attendant and the attendant's overnight hotel and meal expenses if required;
- economy seats to return any covered member of the immediate family who is travelling by with the patient.

DIAGNOSTIC SERVICES - charges for laboratory services for diagnostics and X-rays when ordered by the attending physician.

PARAMEDICAL SERVICES - charges made by a licensed chiropractor, osteopath, chiropodist, podiatrist or physiotherapist (not a relative), up to the usual and customary fee excluding charges for x-rays.

PRESCRIPTIONS - charges for prescription drugs, serums and injectables, approved by Medavie Blue Cross, and purchased on the prescription of a physician (vitamins, patent and proprietary drugs excluded).

DENTAL SERVICES - up to \$2,000 Canadian for dental treatment necessitated by a direct accidental blow to the mouth. Such services must be rendered or reported and approved within 180 days of the accident and be supported by details of the accident.

Treatment to natural teeth for the emergency relief of dental pain, excluding root canals, is covered to a maximum of \$200. Treatment must be performed in a location not less than 200 kilometres beyond the boundary of the province of residence.

VEHICLE RETURN - up to \$1,000 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.

RETURN OF DECEASED - up to \$5,000 Canadian towards the cost of preparation (including cremation) and homeward transportation of a deceased covered person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route. Up to \$2,000 Canadian toward these same costs if the deceased is not returned to Canada.

SUBSTANCE ALLOWANCE - up to \$1,500 Canadian (\$150 per day) per calendar year for extra costs of commercial accommodation and meals incurred by the subscriber, or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending physician and supported with receipts from commercial organizations.

TRANSPORTATION TO VISIT THE COVERED PERSON – one return economy fare by the most direct route for transportation costs (air, bus, train) when the covered person has been confined to hospital for at least seven days or has died, and the attending physician advised the necessary attendance of a family member or close friend of the covered person.

CANASSISTANCE SERVICE – when hospitalization occurs, CanAssistance must be contacted within 24 hours of admission. Failure to contact the assistance provided may result in your medical expenses not being eligible or a delay in the settlement of your claim.

Neither CanAssistance nor Medavie Blue Cross shall be responsible for the availability, quality or result of medical treatment, transportation or other referred services, or the failure of the covered person to obtain medical treatment.

Medical Assistance Services

- provide emergency response in any major language
- refer you to an appropriate physician, clinic or hospital
- confirm your coverage with the hospital or physician
- guarantee or arrange payment to the hospital or physician

Non-Medical Assistance Services

- provide assistance in contacting your family, place of business or family physician
- supervise the medical treatment and keep the family informed
- arrange the transportation of a family member to the patient's bedside or to identify the deceased
- arrange for transportation home of the patient
- arrange for local care of dependent children and coordinate the safe return home if the covered person is hospitalized
- arrange the transmission of urgent messages to family members or business partners
- assistance in the event of loss of passports or airline tickets
- legal counsel referral in the event of a serious accident
- coordinate claims processing and negotiation of health care provider discounts
- provide pre-departure information concerning visas and vaccines

Limitations and Exclusions

Medavie Blue Cross will not pay any benefit or accept any liability for claims relating to the following:

1. Expenses incurred outside the Participant's province of residence when the covered person could have been returned to the Participant's province of residence without endangering their life or health, even if the treatment available in the province of residence may be of lesser quality than the treatment available outside the province of residence.
2. Any covered person travelling outside the province of residence primarily, with the intent or incidentally, to seek medical advice or treatment even if the trip is on the recommendation of a physician.

3. Any hospitalization or service rendered concerning general health examinations for “checkup” purposes; rehabilitation or ongoing care concerning drugs, alcohol, or any other substance abuse; a rest cure or travel for health; or cosmetic purposes.
4. Travel booked or commenced contrary to medical advice.
5. Expenses incurred, directly or indirectly, as a result of Acquired Immune Deficiency Syndrome Complex or other terminal condition.
6. Pregnancy, miscarriage, childbirth or complication of any of these conditions occurring within nine weeks of the expected date of birth.
7. Any claim for patients in a chronic care hospital or in chronic care units of a public hospital, or in nursing homes or health spas.
8. Expenses incurred due to driving a motorized vehicle while impaired by drug or an alcohol level of more than 80 milligrams in 100 millilitres of blood.
9. Any treatment relating to the use or abuse of drugs, alcohol, substances and medications.
10. Suicide, attempted suicide or self-inflicted injury of a person covered under this plan, whether sane or insane.
11. Commission of, or attempt to commit, directly or indirectly, a criminal act under legislation in the area of commission of the offense.
12. Participation in professional sports for remuneration, parachuting or skydiving, gliding, bungee jumping, mountaineering, or a flight accident unless the covered person is riding as a fare paying passenger on a commercial airline or charter aircraft with a seating capacity of six people or more.

13. This Policy excludes loss, damage, cost, or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following, regardless of any other cause or event contributing concurrently or in any other sequence to the loss:

(a) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, chemical, biological or bacteriological warfare, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; or

(b) any act of terrorism. For the purpose of this policy an act of terrorism means an act, including but not limited to: hijacking, the use of force or violence, chemical, biological or bacteriological force and/or the threat thereof, by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological, or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear, that has been determined by the appropriate federal authority to have been an act of terrorism.

(c) any action taken in controlling, preventing, suppressing or in any way relating to (a) and/or (b) above.

14. (a) Expenses in excess of \$1 million Canadian per covered Participant, per incidence outside the province of residence.

(b) A maximum amount of \$5 million will be paid by Medavie Blue Cross for all claims incurred due to any one occurrence. If the total claims payable exceeds \$5 million Canadian, Medavie Blue Cross will pro-rate the payment.

Any one occurrence as used herein means each and every loss, or series of losses, arising out of one accident or cause, regardless of the number of policies or covered persons involved.

**Terms and
Conditions**

All claims and required government forms must be submitted within four (4) months of the date of service.

1. Benefits will be provided with a lifetime maximum of \$1,000,000, in the case of treatment following an emergency resulting from an accident or sudden illness which occurs while travelling outside your province of residence during the term of the contract. (These benefits are over and above what your provincial government health plan will pay, whether in force or not).
2. All amounts indicated in this agreement are in Canadian funds.
3. Payment will be made by Medavie Blue Cross, by cheque, directly to the Participant, or provider of service. Payment will be made in Canadian funds, based on the rate of exchange in effect at the time the service was rendered, as determined by a Canadian chartered bank.
4. All benefit levels outlined in the agreement are per person amounts, unless otherwise stated.
5. Medavie Blue Cross will cover usual, customary and reasonable charges for eligible emergency medical expenses. Benefits listed here shall be payable only on the submission of certification by the attending physician that services were for emergency treatment defined as treatment of an immediate nature required as a result of an unforeseen accident or illness.
6. Medavie Blue Cross has the authority to obtain the Participant's pertinent records or information from any physician, dentist, hospital or clinic.
7. Coverage will be declined if the premium is not received by Medavie Blue Cross due to an invalid form of payment.

8. Only charges for services incurred while the covered person is outside the boundaries of the province of residence, during the term of the contract, will be eligible. Benefits become effective at the time of crossing either the province of residence's boundary or an international border or, if travelling by air, at time the airplane takes off. Benefits expire upon the return to the province of residence or when the airplane lands in the province of residence on the return home.
9. Travel benefits are available to Participants only if they are covered by their provincial health care insurance plan, or equivalent coverage. Participants not covered by their provincial health care insurance plan will be responsible for the payment of any services received to either the provider of services or Medavie Blue Cross.
10. Medavie Blue Cross reserves the right to transfer the Participants to another hospital or return the Participant to Canada. Refusal to comply with the transfer request will absolve Medavie Blue Cross of any further liability.
11. Claims may be denied under this contract if no contact is made with CanAssistance within 24 hours after admission to a hospital.
12. If the air ambulance benefit is used, the unused portion of the Participant's air ticket must be surrendered to Medavie Blue Cross.
13. This contract shall be void if, whether before or after a sickness or injury, a Participant has willfully concealed or misrepresented any material fact or circumstance concerning this coverage.
14. Claim payments under this contract will not carry interest.
15. Medavie Blue Cross and CanAssistance reserve the right to transfer Participants to a preferred provider of health care services. If the Participant refuses to transfer to the recommended provider, claims may be denied.

Claims Procedures

1. To open a claim, Participants are requested to contact CanAssistance. Your coverage will then be validated and payment to the health care provider guaranteed.

2. For those claims where CanAssistance is not being used, please forward your original detailed paid-in-full receipts to Medavie Blue Cross. If necessary, Medavie Blue Cross will return to you the appropriate forms for completion. This is required for coordinating eligible benefits with your provincial health care plan. Once we have received this documentation, prompt assessment of your claim will be made.
3. All claims and required government forms must be submitted within six months of the date of service.
4. All medically-related claims must include a diagnosis and details of services rendered.
5. If funds have been advanced to you by Medavie Blue Cross or CanAssistance, it is the responsibility of the Participant to reimburse these funds should you receive payment from another carrier or your provincial health care plan, or if the services are deemed ineligible at the time of the assessment.

Co-ordination of Benefits

1. This contract is classified as a supplemental benefit plan. It covers expenses not covered under any other benefit or insurance plan, collectible or otherwise. In the event a covered person is entitled to similar benefits under any other individual or group contracts, including but not limited to your provincial health care insurance plan, Workers' Compensation, credit card coverage, and private or auto insurance, benefits will be coordinated with those plans so claims paid do not exceed 100% of the allowable expenses paid.
2. After the benefit payable by government plans has been determined, the excess benefits of this agreement will be coordinated with those of other contracts or plans if the covered person is eligible for similar benefits.
 - (a) If any other plan does not contain a provision for coordination with or reduction of benefits payable under this agreement, the benefits payable under any such plan will be determined first.

- (b) If any other plan contains a provision for coordination with or reduction of benefits payable under this agreement, the benefits shall be coordinated with all other plans to establish an order of benefit determination. The benefits shall be prorated between or among the plans in proportion to the amounts that would have been paid under each plan had there been coverage by just that plan.

Please contact Medavie Blue Cross at the following location to answer any inquiries you may have relating to your benefit plan.

*Medavie Blue Cross
185 The West Mall
Suite 1200
PO Box 2000
Etobicoke ON M9C 5P1*

*Toll Free: 1-800-355-9133
Local Tel.: 416-626-3788
E-Mail: Inquiry.medavie.bluecross.ca*

CanAssistance:
1-800-281-1474 (calling within Canada/US)
(416) 425-2076 (calling from elsewhere in the world)

Respecting Your Privacy

At Sun Life Financial, 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 investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. 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 website at www.sunlife.ca, or send a written request by e-mail to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5 to request that a copy of our Privacy Brochure be sent to you.

