

Council of Academic Hospitals of Ontario (CAHO)

Plan Document Number: G0086936

Plan F: London Health Science Centre - Plan A

Employee Name: _____

Certificate Number: _____

Welcome to Your Group Benefit Program

Plan Document Effective Date: January 1, 2012

This Benefit Booklet has been specifically designed with your needs in mind, providing easy access to the information you need about the benefits to which you are entitled.

Group Benefits are important, not only for the financial assistance they provide, but for the security they provide for you and your family, especially in case of unforeseen needs.

Your employer can answer any questions you may have about your benefits, or how to submit a claim.

This booklet produced: May 18, 2022

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This Benefit Summary provides information about the specific benefits supplied by Manulife Financial that are part of your Group Plan.

Extended Health Care

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - \$15 Individual, \$25 Family, per Benefit Year

Benefit Percentage (Co-insurance)

100% for

- Hospital Care
- Drugs
- Vision Care
- Professional Services
- Medical Supplies and Services

Note:

The Benefit Percentage for Out-of-Province/Canada physician's fees and semi-private hospital accommodation is 100%.

Termination Age - employee's age 70 or retirement, whichever is earlier

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs which by law or convention require a written prescription of a physician or dentist
- smoking cessation aids (including Natural Health Products licensed for sale in Canada by Health Canada)
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)

Charges for the following expenses are not covered:

- the administration of serums, vaccines, or injectable drugs
- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis
- drugs determined to be ineligible as a result of due diligence

Benefit Summary

- any deductible or co-payment the person is required to satisfy under the Ontario Drug Benefit Program
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Anti-smoking drugs - \$300 per lifetime (including Natural Health Products)

All other covered drug expenses - unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

Reimbursement at the cost of a prescribed drug, where a lower cost alternative drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lower cost alternative drug cannot be tolerated or is ineffective.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, to a maximum of 1 exam in any 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$375 in any 24 consecutive months

Professional Services

- Chiropractor: \$500 per Benefit Year
- Podiatrist/Chiropodist: \$500 per Benefit Year
- Massage Therapist: \$650 per Benefit Year
- Speech Therapist: \$500 per Benefit Year
- Physiotherapist: \$500 per Benefit Year
- Psychologist/Social Worker (MSW)/Psychotherapist: \$1,000 per Benefit Year
- Acupuncturist: \$500 per Benefit Year

Benefit Summary

Dental Care

The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Dental Association Approved Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

85% for Basic Services - Level I

85% for Supplementary Basic Services - Level II

Benefit Maximums

unlimited for Level I and Level II

Termination Age - employee's age 70 or retirement, whichever is earlier

Designed with Your Needs in Mind

The Benefit Booklet provides the information you need about your Group Benefits and has been specifically designed with YOUR needs in mind. It includes:

- a detailed Table of Contents, allowing quick access to the information you are searching for,
- Explanation of Commonly Used Terms, which provides a brief explanation of the terms used throughout this Benefit Booklet,
- a clear, concise explanation of your Group Benefits, and
- information you need, and simple instructions, on how to submit a claim.

Important Note

The purpose of this booklet is to outline the benefits for which you are eligible as an employee of Council of Academic Hospitals of Ontario (CAHO). The information in this booklet is a summary of the provisions of the Plan Document for the Extended Health Care and Dental Care Benefits. In the event of a discrepancy between this booklet and the Plan Document (both available from your employer), the terms of the Plan Document will apply.

The Life Insurance described in this booklet is insured by Sun Life Insurance Company of Canada. Your Plan Sponsor has provided this wording for use in this booklet and is responsible for ensuring it is accurate, up to date and consistent with the governing policy. Manulife Financial is not responsible for any claims in connection with the booklet wording relating to this benefit. In the event of a discrepancy between this booklet and the policy, the terms of the group policy will apply. Manulife shall not be responsible for any detrimental reliance that you may place upon this information whatsoever.

The booklet is provided for information purposes only and does not create or confer any contractual rights or obligations.

Possession of this booklet alone does not mean that you or your dependents are covered. The Plan Document must be in effect and you must satisfy all the requirements of the Plan.

Where required by law, you or any claimant under the Plan Document has the right to request a copy of any or all of the following items:

- the Plan Document,
- your application for group benefits, and
- any Evidence of Insurability you submitted as part of your application for benefits.

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the Plan Document.

Manulife Financial reserves the right to charge you for such documentation after your first request.

We suggest you read this Benefit Booklet carefully, then file it in a safe place with your other important documents.

How to Use Your Benefit Booklet

Your Group Benefit Card

Your Group Benefit Card is the most important document issued to you as part of your Group Benefit Program. It is the only document that identifies you as a Plan Member. The Plan Document Number and your personal Certificate Number may be required before you are admitted to a hospital, or before you receive dental or medical treatment.

The Plan Document Number and your Certificate Number are also necessary for ALL correspondence with Manulife Financial. Please note that you can print your Certificate Number on the front of this booklet for easy reference.

Your Group Benefit Card is an important document. Please be sure to carry it with you at all times.

Explanation of Commonly Used Terms

The following is an explanation of the terms used in this Benefit Booklet.

Adherence

use drug, service or supply in accordance with the terms for which it was prescribed.

Advisory Body

Manulife Financial approved external experts that may provide Manulife Financial with recommendations, applying a pharmacoeconomic or cost effectiveness evaluation.

Benefit Percentage (Co-insurance)

the percentage of Covered Expenses which is payable by your employer.

Benefit Year

the period from July 1st to June 30th.

Covered Expenses

expenses that will be considered in the calculation of payment due under your Extended Health Care or Dental Care benefit.

Deductible

the amount of Covered Expenses that must be incurred and paid by you or your dependents before benefits are payable by your employer.

Dependent

your Spouse or Child who is covered under the Provincial Plan.

- Spouse

your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least 12 months.

- Child

- your natural or adopted child, foster child or stepchild, who is:
 - unmarried
 - under age 21,
 - not employed on a full-time basis, and
 - not eligible for coverage as an employee under this or any other Group Benefit Program
- a child who is incapacitated on the date he or she reaches the age when coverage would normally terminate will continue to be an eligible dependent. However, the child must have been covered under this Benefit Program immediately prior to that date.

A child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependent on the employee for support, maintenance and care, due to a mental or physical handicap.

Explanation of Commonly Used Terms

Your employer may require written proof of the child's condition as often as may reasonably be necessary.

- a stepchild must be living with you to be eligible

Disease Management Programs

an approach to healthcare that teaches patients how to manage a chronic disease. A system of coordinated healthcare interventions and communications for patients with conditions in which patient self-care efforts are significant in the management of their condition.

Drug

a medication that has been approved for use by Health Canada and has a Drug Identification Number.

Due Diligence

a process employed by Manulife Financial to assess new drugs, existing drugs with new indications, services or supplies to determine eligibility under the Plan Document. This process may use pharmacoeconomics, cost effectiveness analysis reference information from existing Federal or Provincial formularies, recognized clinical practice guidelines, or an advisory body.

Exclusive Distribution

Manulife Financial approved vendors.

Experimental or Investigational

not approved as an effective, appropriate and essential treatment of an illness or injury.

Immediate Family Member

you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

Interchangeable Drug

includes but is not limited to:

- a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed, or
- a drug that contains the same active ingredient that has not been deemed interchangeable in the province where the drug is dispensed; but has been identified as interchangeable by Manulife Financial.

Licensed, Certified, Registered

the status of a person who legally engages in practice by virtue of a license or certificate issued by the appropriate authority, in the place where the service is provided.

Life-Sustaining Drugs

non-prescription drugs which are necessary to sustain life.

Explanation of Commonly Used Terms

Lower Cost Alternative

if two or more drugs, supplies or services result in therapeutically similar results, or prescribing guidelines recommend alternate drugs, supplies or services be tried first that are lower in cost, the lower cost alternative will be considered.

Medically Necessary

accepted and recognized by the Canadian medical profession and Manulife Financial as effective, appropriate and essential treatment of an illness or injury. Manulife Financial has the right after due diligence has been completed to determine whether the drug, service or supply is covered under the Plan Document.

Natural Health Products

products licensed for sale in Canada by Health Canada as a Natural Health Product.

Patient Assistance Program

a program that provides assistance to you or your dependents who are prescribed select drugs, supplies or services. Manufacturers and distributors may provide patient assistance programs that include financial support, along with education and training.

Pharmacoeconomics

the scientific discipline that evaluates the value of pharmaceutical drugs, clinical services or supplies. This discipline includes but is not limited to clinical evaluations, risk analysis, economic value and the cost consequences to plans. Pharmacoeconomic studies serve to guide optimal healthcare resource allocation, in a standardized and scientifically grounded manner as determined by Manulife Financial.

Prior Authorization

a claims management feature applied to a specific list of drugs, supplies or services to determine eligibility based on predefined clinical criteria and a pharmacoeconomic or cost effectiveness evaluation.

Provincial Plan

any plan which provides hospital, medical, or dental benefits established by the government in the province where the covered person lives.

Reasonable and Customary

the lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial,
- the amount shown in the applicable professional association fee guide, or
- the maximum price established by law.

Explanation of Commonly Used Terms

Waiting Period

the period of continuous employment with your employer which you must complete before you are eligible for Group Benefits.

Ward

a hospital room with 3 or more beds which provides standard accommodation for patients.

Why Group Benefits?

Government health plans can provide coverage for such basic medical expenses as hospital charges and doctors' fees. In case of disability, government plans (such as Employment Insurance, Canada/Quebec Pension Plan, Workers' Compensation Act, etc.) may provide some financial assistance.

But government plans provide only basic coverage. Medical expenses or a disability can create financial hardship for you and your family.

Private health care and disability programs supplement government plans and can provide benefits not available through any government plan, providing security for you and your family when you need it most.

Your Employer's Representative

Your employer is responsible for ensuring that all employees are covered for the Benefits to which they are entitled by reporting all new enrolments, terminations, changes, etc., and keeping all records up to date.

As a member of this Group Benefit Program, it is up to you to provide your employer with the necessary information to perform such duties.

Your Employer's Representative is: _____
Phone Number: _____

Please record the name of your representative and the contact number in the space provided.

Applying for Group Benefits

To apply for Group Benefits, you must submit a completed Enrolment or Re-enrolment Application form, available from your employer. Your employer then forwards the application to Manulife Financial.

Making Changes

To ensure that coverage is kept up to date for yourself and your dependents, it is vital that you report any changes to your employer. Such changes could include:

- change in Dependent Coverage
- applying for coverage previously waived
- change in Name

The Claims Process

Naming a Beneficiary

Manulife Financial does not accept beneficiary designations for any benefits under this Plan.

This Plan contains a provision removing or restricting the right of the covered person to designate persons to whom or for whose benefit money is to be payable.

How to Submit a Claim

All claim forms, available from your employer, must be correctly completed, dated and signed. Remember, always provide your Plan Document Number and your Certificate number (found on your Group Benefit Card) to avoid any unnecessary delays in the processing of your claim.

Your employer can assist you in properly completing the forms, and answer any questions you may have about the claims process and your Group Benefit Program.

Payment of Extended Health Care and Dental Claims

Once the claim has been processed, Manulife Financial will send a Claim Statement to you.

The top portion of this form outlines the claim or claims made, the amount subtracted to satisfy deductibles, and the benefit percentage used to determine the final payment to be made to you. If you have any questions on the amount, your employer will help explain.

The bottom portion of this form is your claims payment, if applicable. Simply tear along the perforated line, endorse the back of the cheque and you can cash it at any chartered bank or trust company.

You should receive settlement of your claim within three weeks from the date of submission to Manulife Financial. If you have not received payment, please contact your employer.

Co-ordination of Extended Health Care and Dental Care Benefits

If you or your dependents are covered for similar benefits under another Plan, this information will be taken into account when determining the amount of expenses payable under this Program.

This process is known as Co-ordination of Benefits. It allows for reimbursement of covered medical and dental expenses from all Plans, up to a total of 100% of the actual expense incurred.

Plan means:

- other Group Benefit Programs;
- any other arrangement of coverage for individuals in a group; and
- individual travel insurance plans.

Plan does not include school insurance or Provincial Plans.

Order of Benefit Payment

A variety of circumstances will affect which Plan is considered as the “Primary Carrier” (ie., responsible for making the initial payment toward the eligible expense), and which Plan is considered as the “Secondary Carrier” (ie., responsible for making the payment to cover the remaining eligible expense).

- If the other Plan does not provide for Co-ordination of Benefits, it will be considered as the Primary Carrier, and will be responsible for making the initial payment toward the eligible expense.
- If the other Plan does provide for Co-ordination of Benefits, the following rules are applied to determine which Plan is the Primary Carrier.

- For Claims incurred by you or your Dependent Spouse:

The Plan covering you or your Dependent Spouse as an employee/member pays benefits before the Plan covering you or your Spouse as a dependent.

In situations where you or your Spouse have coverage as an employee/member under more than one Plan, the order of benefit payment will be determined as follows:

- The Plan where the person is covered as an active full-time employee, then
- The Plan where the person is covered as an active part-time employee, then
- The Plan where the person is covered as a retiree.

- For Claims incurred by your Dependent Child:

The Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

However, if you and your Spouse are separated or divorced, the following order applies:

- The Plan of the parent with custody of the child, then
- The Plan of the spouse of the parent with custody of the child (i.e., if the parent with custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child), then
- The Plan of the parent not having custody of the child, then
- The Plan of the spouse of the parent not having custody of the child (i.e., if the parent without custody of the child remarries or has a common-law spouse, the new spouse's Plan will pay benefits for the Dependent Child).
- Where you and your spouse share joint custody of the child, the Plan covering the parent whose birthday (month/day) is earlier in the calendar year pays benefits first. If both parents have the same birthdate, the Plan covering the parent whose first name begins with the earlier letter in the alphabet pays first.

The Claims Process

- A claim for accidental injury to natural teeth will be determined under Extended Health Care Plans with accidental dental coverage before it is considered under Dental Plans.
- If the order of benefit payment cannot be determined from the above, the benefits payable under each Plan will be in proportion to the amount that would have been payable if Co-ordination of Benefits did not exist.
- If the person is also covered under an individual travel insurance plan, benefits will be co-ordinated in accordance with the guidelines provided by the Canadian Life and Health Insurance Association.

Submitting a Claim for Co-ordination of Benefits

To submit a claim when Co-ordination of Benefits applies, refer to the following guidelines:

- As per the Order of Benefit Payment section, determine which Plan is the Primary Carrier and which is the Secondary Carrier.
- Submit all necessary claim forms and original receipts to the Primary Carrier.
- Keep a photocopy of each receipt or ask the Primary Carrier to return the original receipts to you once your claim has been settled.
- Once your claim has been settled by the Primary Carrier, you will receive a statement outlining how your claim has been handled. Submit this statement along with all necessary claim forms and receipts to the Secondary Carrier for further consideration of payment, if applicable.

Eligibility

You are eligible for Group Benefits if you:

- are a full-time employee of Council of Academic Hospitals of Ontario (CAHO) and work at least the Required Number of Hours,
- are a member of an eligible class,
- are younger than the Termination Age,
- are residing in Canada, and
- have completed the Waiting Period.

The Termination Age and Waiting Period may vary from benefit to benefit. For this information, please refer to each benefit in the section entitled Your Group Benefits.

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

Required Number of Hours

Full-time employee - normal work schedule.

Medical Evidence

Medical evidence is required for all benefits, except Dental, when you make a Late Application for coverage on any person. Medical evidence is required when you apply for coverage in excess of the Non-Evidence Limit.

Late Application

If you apply for benefits that were previously waived because you were covered for similar benefits under your spouse's plan, your application is considered late when you:

- apply for benefits more than 31 days after the date benefits terminated under your spouse's plan; or
- apply for benefits, and benefits under your spouse's plan have not terminated.

Medical evidence can be submitted by completing the Evidence of Insurability form, available from your employer. Further medical evidence may be requested by Manulife Financial.

Late Dental Application

If you apply for coverage for Dental for yourself or your dependents late, the benefit will be limited to \$150 for each covered person for the first 12 months of coverage.

Who Qualifies for Coverage?

Effective Date of Coverage

- If medical evidence is not required, your Group Benefits will be effective on the date you are eligible.
- If medical evidence is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for plan benefit coverage to become effective. If you are not actively at work on the date your coverage would normally become effective, your coverage will take effect on the next day on which you are again actively at work.

Your dependent's coverage becomes effective on the date the dependent becomes eligible, or the date any required medical evidence on the dependent is approved by Manulife Financial, whichever is later.

Your dependent's coverage will not be effective prior to the date your coverage becomes effective.

Termination of Coverage

Your Group Benefit coverage will terminate on the earliest of:

- the date you cease to be an eligible employee
- the date you cease to be actively at work, unless the Plan Document allows for your coverage to be extended beyond this date
- the date your employer terminates coverage
- the date you enter the armed forces of any country on a full-time basis
- the date the Plan Document terminates or coverage on the class to which you belong terminates
- the date you reach the Termination Age
- the date of your death

Your dependents' coverage terminates on the date your coverage terminates or the date the dependent ceases to be an eligible dependent, whichever is earlier.

Extended Health Care

Your Extended Health Care Benefit is provided directly by Council of Academic Hospitals of Ontario (CAHO). Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your dependents incur charges for any of the Covered Expenses specified, your Extended Health Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

Drug Benefit and Pharmacy Services for Quebec Residents

Group benefit plans that provide prescription drug coverage to Quebec residents must meet certain requirements under Quebec's prescription drug insurance and pharmacy services insurance legislation (An Act Respecting Prescription Drug Insurance and the Health Insurance Act And Amending Various Legislative Provisions). If you and your dependents reside in Quebec, the provisions specified under Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec, will apply to your drug benefit.

The Benefit

Overall Benefit Maximum - Unlimited

Deductible - \$15 Individual, \$25 Family, per Benefit Year

- Deductible Carry-Forward

Covered Expenses used to satisfy the deductible in the last 3 months of the Benefit Year may also be used to satisfy the deductible in the following Benefit Year.

Benefit Percentage (Co-insurance)

100% for

- Hospital Care
- Drugs
- Vision Care
- Professional Services
- Medical Supplies and Services

Note:

The Benefit Percentage for Out-of-Province/Canada physician's fees and semi-private hospital accommodation is 100%.

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Your Group Benefits

Covered Expenses

The expenses specified are covered to the extent that they are reasonable and customary, as determined by Manulife Financial or your employer, provided they are:

- medically necessary for the treatment of an illness or injury and recommended by a physician
- incurred for the care of a person while covered under this Group Benefit Program
- reasonable taking all factors into account
- not covered under the Provincial Plan or any other government-sponsored program
- legally insurable
- used as prescribed or recommended by a physician
- associated with any drug, supply or service that was subject to the due diligence process, the process has been completed with the result that expenses for that drug, supply or service are eligible under the plan as of the date of approval as determined by the administrator and shared with your employer as required.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program excludes, discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, this plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

This plan will not automatically assume eligibility for all drugs, services and supplies. New drugs, existing drugs with new indications, services and supplies are reviewed by Manulife Financial using the due diligence process. Once this process has been completed, the decision will be made by Manulife Financial to include as a covered expense, include with prior authorization criteria, exclude or apply maximum limits.

Manulife Financial maintains a list of drugs, services and supplies that require prior authorization. Prior authorization is applied to ensure that the therapy prescribed is medically necessary. Where there are lower cost alternative treatments or prescribing guidelines recommend alternative drugs be tried first that are lower in cost, you or your eligible dependents will be required to have tried an alternative treatment unless medical contraindications to alternative treatments exist.

At Manulife Financial's discretion, medical information, test results or other documentation will be required from your physician to determine the eligibility of the drug, service or supply.

Manulife Financial has the right to ensure you or your dependents access Manulife Financial's exclusive distribution channels where applicable when purchasing a drug, service or supply. Manulife Financial may decline a drug, service or supply purchased from a provider outside the exclusive distribution channel.

Adherence

Non-compliance may result in the drug, service or supply no longer being eligible for reimbursement.

Patient Assistance Programs

Manulife Financial may require you or your dependents to apply to and participate in any patient assistance program to which you or your dependents are entitled. Manulife Financial reserves the right to reduce the amount of a covered expense by the amount of financial assistance you or your dependents are entitled to receive under a patient assistance program.

Disease Management Programs

Participation in a disease management program may be required. Participation will be at the discretion of Manulife Financial.

Advance Supply Limitation

Payment of any Covered Expenses under this benefit which may be purchased in large quantities will be limited to the purchase of up to a 3 months' supply at any one time.

- Drug Expenses

The maximum quantity of drugs that will be payable for each prescription will be limited to the lesser of:

- a) the quantity prescribed by your physician or dentist, or
- b) a 34 day supply.

A quantity of up to a 100 day supply may be payable in long term therapy cases, where the larger quantity is recommended as appropriate by your physician and pharmacist.

Hospital Care

- private accommodation for confinement in a private hospital for charges incurred for treatment of addictions or eating disorders, up to 120 days to a maximum of \$7,000 per lifetime
- charges for any portion of the cost of ward accommodation, utilization or co-payment fees (or similar charges) are not covered
- Reasonable and Customary charges will apply.

ManuScript Generic Drug Plan 2 - Prescription Drugs

Charges incurred for the following expenses are payable when prescribed in writing by a physician or dentist and dispensed by a licensed pharmacist.

- drugs which by law or convention require a written prescription of a physician or dentist
- smoking cessation aids (including Natural Health Products for sale in Canada by Health Canada)
- oral contraceptives, intrauterine devices and diaphragms
- injectable medications
- life-sustaining drugs
- preventive vaccines and medicines (oral or injected)
- non-prescription drugs and supplies required for the treatment of diabetes (excluding automatic jet injectors or similar equipment)

Charges for the following expenses are not covered:

- the administration of serums, vaccines, or injectable drugs
- drugs, biologicals and related preparations which are administered in hospital on an in-patient or out-patient basis

Your Group Benefits

- drugs determined to be ineligible as a result of due diligence
- any deductible or co-payment the person is required to satisfy under the Ontario Drug Benefit Program
- drugs used in the treatment of a sexual dysfunction

- Drug Maximums

Anti-smoking drugs - \$300 per lifetime (including Natural Health Products)

All other covered drug expenses - unlimited

- Payment of Covered Expenses

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

Covered expenses for any prescribed drug will not exceed the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

Manulife Financial can limit the covered expense for any drug to that of a lower cost interchangeable drug at the time the drug is purchased.

If there is no lower cost alternative drug for the prescribed drug, the amount payable is based on the cost of the prescribed drug.

- No Substitution Prescriptions

If your prescription contains a written direction from your physician or dentist that the prescribed drug is not to be substituted with another product, the maximum amount covered is the price of the lower cost alternative drug that can legally be used to fill the prescription, as listed in the Provincial Drug Benefit Formulary or a lower cost alternative that provides therapeutically similar results as identified by Manulife Financial.

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Reimbursement at the cost of a prescribed drug, where a lower cost alternative drug is available, will only be considered if medical evidence is provided by the treating physician to support why the lower cost alternative drug cannot be tolerated or is ineffective.

Payment of your covered drug expenses will be subject to any Drug Deductible, any Drug Dispensing Fee Maximum, the Benefit Percentage for drugs and any maximum.

- Payment of Drug Claims

Your Pay Direct Drug Card provides your pharmacist with immediate confirmation of covered drug expenses. This means that when you present your Pay Direct Drug Card to your pharmacist at the time of purchase, you and your eligible dependents will not incur out-of-pocket expenses for the full cost of the prescription.

The Pay Direct Drug Card is honoured by participating pharmacists displaying the appropriate Pay Direct Drug decal.

To fill a prescription for covered drug expenses:

- a) present your Pay Direct Drug Card to the pharmacist at the time of purchase, and
- b) pay any amounts that are not covered under this benefit.

You will be required to pay the full cost of the prescription at time of purchase if:

- you cannot locate a participating Pay Direct Drug pharmacy
- you do not have your Pay Direct Drug Card with you at that time
- the prescription is not payable through the Pay Direct Drug Card system

For details on how to receive reimbursement after paying the full cost of the prescription, please see your Plan Administrator.

Vision Care

- eye exams, to a maximum of 1 exam in any 24 consecutive months
- purchase and fitting of prescription glasses or elective contact lenses, as well as repairs, or elective laser vision correction procedures, to a maximum of \$375 in any 24 consecutive months

Professional Services

Services provided by the following licensed practitioners:

- Chiropractor: \$500 per Benefit Year
- Podiatrist/Chiropodist: \$500 per Benefit Year
- Massage Therapist: \$650 per Benefit Year
- Speech Therapist: \$500 per Benefit Year
- Physiotherapist: \$500 per Benefit Year
- Psychologist/Social Worker (MSW)/Psychotherapist: \$1,000 per Benefit Year
- Acupuncturist: \$500 per Benefit Year

Expenses for some of these Professional Services may be payable in part by Provincial Plans. Coverage for the balance of such expenses prior to reaching the Provincial Plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this Benefit Program are payable after the Provincial Plan's maximum for the benefit year has been paid.

Professional Services of a Massage Therapist are not subject to reasonable and customary limitations.

Recommendation by a physician for Professional Services is not required, except for services of a Massage Therapist which is required once per lifetime.

Medical Services and Supplies

For all medical equipment and supplies covered under this provision, Covered Expenses will be limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Your Group Benefits

Private Duty Nursing

Services which are deemed to be within the practice of nursing and which are provided in the patient's home by a registered nurse or a registered practical nurse.

Charges for the following services are not covered:

- service provided primarily for custodial care, homemaking duties, or supervision
- service performed by a nursing practitioner who is an immediate family member or who lives with the patient
- service performed while the patient is confined in a hospital, nursing home, or similar institution
- service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient's household

Pre-Determination of Benefits

Before the services begin, it is advisable that you submit a detailed treatment plan with cost estimates. You will then be advised of any benefit that will be provided.

Ambulance

- licensed ambulance service provided in the patient's province of residence, including air ambulance, to transfer the patient to the nearest hospital where adequate treatment is available

Medical Equipment

- rental or, when approved by Manulife Financial, purchase of:
 - Mobility Equipment: crutches, canes, walkers, and wheelchairs
 - Durable Medical Equipment: manual hospital beds, respiratory and oxygen equipment, and other durable equipment usually found only in hospitals

Non-Dental Prostheses and Supports

- external prostheses. Charges for breast prostheses are subject to a maximum of 6 per Benefit Year.
- intra-ocular lens implants, contact lenses or cataract eyeglasses required as a substitute for a covered person's natural lens following cataract surgery or when the covered person lacks an organic lens, limited to 1 lens per eye per lifetime
- surgical stockings, to a maximum of 6 pairs per Benefit Year. **Note:** Diagnosis required with claim submission.
- surgical brassieres, to a maximum of 6 per Benefit Year
- braces (other than foot braces), trusses, collars, leg orthosis, casts and splints
- modifications or adjustments to stock-item orthopaedic shoes (recommendation of either a physician or a podiatrist is required). Charges for modifications and adjustments to regular footwear are not covered.

- custom-made shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe (must be constructed by a certified orthopaedic footwear specialist)
- casted, custom-made orthotics, \$400 per pair to a maximum of 2 pairs per Benefit Year (recommendation of either a physician or a podiatrist/chiropractist is required)

Other Supplies and Services

- ileostomy, colostomy and incontinence supplies
- medicated dressings and burn garments
- cystistat and uracyst
- wigs and hairpieces for patients with temporary hair loss as a result of medical treatment, up to a maximum of 1 per lifetime
- viscosupplementation
- oxygen
- microscopic and other similar diagnostic tests and services rendered in a licensed laboratory in the province of Quebec
- charges for the treatment of accidental injuries to natural teeth or jaw, provided the treatment begins within 90 days of the accident and is received and approved for payment within 12 months of the accident. However if the covered person is under age 18 at the time of the accident, treatment must be completed prior to attainment of age 19. Injuries due to biting or chewing are excluded.
- breast pumps, to a maximum of \$300 per lifetime
- continuous glucose monitors and flash glucose monitors, up to \$6,000 per individual per Benefit Year

Out-of-Province or Out-of-Canada

- treatment required as a result of a Medical Emergency arising while temporarily outside the province of residence, provided that the covered person who receives the treatment is also covered by the Provincial Plan during the absence from the province of residence.

A Medical Emergency is:

- a sudden, unexpected injury or a new medical condition which occurs while a covered person (you or your dependent) is travelling outside of his province of residence, or
- a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure.

Stable means that, in the 90 days before departure, the covered person (you or your dependent) has not:

- been treated or tested for any new symptoms or conditions
- had an increase or worsening of any existing symptoms

Your Group Benefits

- changed treatments or medications (other than normal adjustments for ongoing care)
- been admitted to the hospital for treatment of the condition

Coverage is not available if you (or your dependents) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition.

Coverage is also available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date.

A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to his home province or territory.

Charges for the following are payable under this expense:

- physician's services
- semi-private hospital room and board
- hospital charges for out-patient treatment

The amount payable for these expenses will be limited to reasonable and customary charges less the amount payable by the Provincial Plan.

Charges incurred outside the province of residence for all other Covered Extended Health Care Expenses are payable on the same basis as if they were incurred in the province of residence.

Submitting a Claim

To submit an Extended Health Care claim, you must complete an Extended Health Care Claim form, except when claiming for physician or hospital expenses incurred outside your province of residence. For these expenses, you must complete an Out-of-Province/Out-of-Canada claim form. Claim forms are available from your employer.

All applicable receipts must be attached to the completed claim form when submitting it to Manulife Financial.

All claims must be submitted within 12 months after the date the expense was incurred.

Claims for Out-of-Canada expenses must first be submitted to the Provincial Plan for payment. Any outstanding balance should be submitted to Manulife Financial, along with the explanation of payment from the Provincial Plan.

Subrogation (Third Party Liability)

If your medical expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

No Extended Health Care benefits are payable for expenses related to:

- for Out-of-Province/Out-of-Canada only, self-inflicted injuries, either directly or indirectly, unless medical evidence establishes that the injuries are related to a mental health illness
- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- an illness or injury for which benefits are payable under any government plan or workers' compensation
- charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of coverage
- services or supplies which are not permitted by law to be paid
- services or supplies which are required for recreation or sports
- services or supplies which would have been payable by the Provincial Plan if proper application had been made
- medical treatment which is not usual or customary, or is experimental or investigational in nature
- medical or surgical care which is cosmetic
- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- services or supplies which are provided while confined in a hospital on an in-patient basis
- services or supplies which are not specified as a covered expense under this benefit
- diabetic appliances and equipment, including insulin pumps and supplies

Your Group Benefits

Drug Benefit and Pharmacy Services For Persons Who Reside In Quebec

If you and your dependents reside in Quebec, the following provisions apply to your drug benefit coverage.

Covered Expenses

The following expenses are covered:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred,
- covered pharmacy services that are to be paid when the drug is on the RAMQ List, and
- drugs that are listed as a covered expense in this Benefit Booklet, but are not on the RAMQ List.

Coverage for drugs on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List) and pharmacy services published for private plans

The following provisions apply to the coverage of drugs that are on the RAMQ List and pharmacy services for private plans, as legislated by An Act Respecting Prescription Drug Insurance and the Health Insurance Act (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in this Benefit Booklet:

a) Benefit Percentage

Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

- For any drug on the RAMQ List which is not otherwise covered under the terms of this Benefit, the percentage payable is the percentage as set out by the then applicable Legislation.
- for any Legislated pharmacy services which are not otherwise covered under the terms of this Benefit, the percentage payable is as set out by the then applicable Legislation.
- For any drug on the RAMQ List which is covered under the terms of this Benefit, the percentage payable is the greater of:
 - the benefit percentage stated under The Benefit, and
 - the percentage as set out by the then applicable Legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is a portion of covered drug expenses or covered pharmacy services which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are:

- deductible amounts,
- the portion of covered drug expenses that is paid by a covered person, when the percentage of covered expenses payable under this benefit is less than 100%, and

- iii) covered pharmacy services that are performed by pharmacists for drugs on the RAMQ formulary.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the Legislation and includes those portions of covered drug expenses and covered pharmacy services relating to a drug on the RAMQ formulary paid for your dependent children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses and covered pharmacy services paid for your dependent children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) **Deductible**

Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is reached. Thereafter, the deductible will not apply.

d) **Lifetime Maximums**

Lifetime maximums (if any) will not apply to drugs on the RAMQ List or covered pharmacy services. Drug and covered pharmacy service coverage provided after the lifetime maximum amount stated under the benefit is reached is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,
- ii) only covered pharmacy services that are performed for drugs on the RAMQ List are covered, and
- iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

e) **Eligible Dependent Children**

Your eligible dependent children who are in full-time attendance at an accredited educational institution will be covered until the later of:

- i) the age specified in this Benefit Booklet (please refer to definition of child in the Explanation of Common Insurance Terms), and
- ii) age 26.

Drug coverage and covered pharmacy services provided for dependent children after the age stated in this Benefit Booklet is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,
- ii) only covered pharmacy services performed for a drug in the RAMQ List are covered, and
- iii) the percentage payable by the Administrator for covered expenses is the percentage as set out by the then applicable Legislation.

f) **Termination Age for Covered Drug and Pharmacy Service Expenses**

Provided you are otherwise eligible for the drug benefit, the Termination Age (if any) for the drug benefit will not apply. Drug coverage provided after the Termination Age specified under the benefit is subject to the following conditions:

- i) only drugs that are on the RAMQ List are covered,

Your Group Benefits

- ii) only covered pharmacy services related to a drug on the RAMQ List are covered,
- iii) the percentage payable by the Administrator for covered expenses is the percentage as stipulated in the then applicable Legislation,
- iv) the Annual Out-of-Pocket Maximum is as stipulated in the then applicable Legislation, and
- v) the cost required for the drug coverage is the cost of the Extended Health Care benefit.

Coverage for drugs that are listed as a covered expense in this Benefit Booklet but are not on the RAMQ List

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Dental Care

Your Dental Care Benefit is provided directly by Council of Academic Hospitals of Ontario (CAHO). Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following the standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

If you or your dependents require any of the dental services specified under Covered Expenses, your Dental Care benefit can provide financial assistance.

Payment of Covered Expenses is subject to any maximum amounts shown below under The Benefit and in the expenses listed under Covered Expenses.

Claim amounts that will be applied to the maximum are the amounts paid after applying the Deductible, Benefit Percentage, and any other applicable provisions.

The Benefit

Deductible - Nil

Dental Fee Guide - Current Ontario Dental Association Approved Fee Guide for General Practitioners

Benefit Percentage (Co-insurance)

85% for Basic Services - Level I

85% for Supplementary Basic Services - Level II

Benefit Maximums

unlimited for Level I and Level II

Termination Age - employee's age 70 or retirement, whichever is earlier

Waiting Period

none for employees hired on or prior to the Plan Document Effective Date
none for all other employees

Covered Expenses

The following expenses are covered if they:

- are incurred for the necessary dental care of a covered person while covered under this benefit
- are incurred for services provided by a dentist, a dental hygienist working within the scope of his license, or a denturist working within the scope of his license
- are reasonable as determined by your employer or Manulife Financial, taking all factors into account
- do not exceed the fees recommended in the Dental Fee Guide, or reasonable and customary charges as determined by your employer or Manulife Financial, if the expenses are not listed in the Dental Fee Guide

Alternate Treatment

Where any two or more courses of treatment covered under this benefit would produce professionally adequate results for a given condition, your employer will pay benefits as if the least expensive course of treatment were used. Your administrator will determine the adequacy of the various courses of treatment available, through a professional dental consultant.

Level I – Basic Services

- complete oral exam, once per 36 months
- full-mouth x-rays, once per 36 months
- panoramic x-rays, once per 36 months
- one unit of light scaling and one unit of polishing, once every 6 months for dependent children under age 18 and once every 9 months for any other person, when the service is performed outside Quebec, or prophylaxis (polishing), once every 6 months for dependent children under age 18 and once every 9 months for any other person, when the service is performed in Quebec
- recall exams, bitewing x-rays and fluoride treatments, once every 6 months for dependant children under age 18 and once every 9 months for any other person
- routine diagnostic and laboratory procedures
- oral hygiene instruction, once every 6 months for dependant children under age 18 and once every 9 months for any other person
- fillings, retentive pins and pit and fissure sealants. Replacement fillings are covered provided:
 - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or
 - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam
- pre-fabricated full coverage restorations (metal and plastic)
- minor surgical procedures and post surgical care
- extractions (including impacted and residual roots)

Your Group Benefits

- consultation, anaesthesia, including local anaesthesia and conscious sedation
- denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture
- injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery
- microbiological tests for determination of pathologic agents
- unscheduled office/institutional appointments
- cephalometric films and tracing of cephalometric films
- sinus exams
- bacteriological tests for determination of dental caries susceptibility

Level II – Supplementary Basic Services

- surgical procedures not included in Level I (excluding implant surgery)
- periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:
 - scaling not covered under Level I, and root planing
 - provisional splinting
 - occlusal equilibration, up to a maximum of 8 units per calendar year
 - oral mucosal disorder
- endodontic services which include root canals and therapy, root amputation, apexifications, chemical bleaching and periapical services
 - root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime
 - re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment
- treatment of fractures
- management of temporomandibular joint (TMJ) dislocation. Treatment rendered for a full mouth reconstruction, for a vertical dimension, or for a correction of temporomandibular joint dysfunction, is not eligible as indicated under Exclusions.

Late Entrant Limitation

If you apply for coverage for Dental for yourself or your dependents late, the benefit will be limited to \$150 for each covered person for the first 12 months of coverage.

Pre-Determination of Benefits

If the cost of any proposed dental treatment is expected to exceed \$500, it is suggested that you submit a detailed treatment plan, available from your dentist, before the treatment begins. You can then be advised of the amount you are entitled to receive under this benefit.

Work in Progress When Coverage Terminates

Covered expenses related to dental treatment that was in progress at the time your dental benefits terminate (for reasons other than termination of the Plan Document or the Dental Care Benefit) are payable, provided the expense is incurred within 31 days after your benefit terminates.

Submitting a Claim

To submit a claim, you and your dentist must complete a Dental Claim form available from your employer.

All claims must be submitted within 12 months after the date the expense was incurred.

Subrogation (Third Party Liability)

If your dental expenses result from an injury caused by another person and you have the legal right to recover damages, your employer may request that you complete a subrogation reimbursement agreement when you submit a claim for such expenses.

On settlement or judgement of your legal action, you will be required to reimburse your employer those amounts you recover which, when added to the payments you received from your employer, exceed 100% of your incurred expenses.

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- committing or attempting to commit an assault or criminal offence
- injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol
- dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was covered under this benefit
- anti-snoring or sleep apnea devices
- broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms
- services which are payable by any government plan
- services or supplies provided by an employer's medical or dental department
- services or supplies for which no charge would normally be made in the absence of group benefit coverage
- treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction, except for management of temporomandibular joint dislocation
- replacement of removable dental appliances which have been lost, mislaid or stolen
- laboratory fees which exceed reasonable and customary charges

Your Group Benefits

- services or supplies which are performed or provided by the covered person, an immediate family member or a person who lives with the covered person
- implants, or any services rendered in conjunction with implants
- treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition
- services or supplies which are not specified as a covered expense under this benefit

Your Group Insurance Booklet

Group Policy No. 87989

Keep in a safe place

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

Your Plan Administrator is there to help

Your plan administrator can:

- help you enrol in the plan
- provide you with the forms you need to claim group benefits
- answer any questions you may have

Benefits and claims information at your fingertips

For more information about your group benefits or claims, please call Sun Life's Customer Care Centre toll-free number at 1-800-361-6212.

We're on the Internet!

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

Our address is:

www.sunlife.ca

Accessing your records

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the policy.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

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

Other Carrier Benefits

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or to obtain information about our privacy practices, 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.

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

Summary of Insurance**Policy Number 87989****Life Insurance**

Class of Members	Benefit Formula	Maximum Benefit
1. All eligible Interns and Residents who are employed by Participating Hospitals and who are on the payroll of such Hospitals	2x annual earnings*	\$300,000
2. All eligible Interns and Residents who are training and residing in Canada, while being sponsored by their respective countries	--	\$152,000

*rounded to the nearest \$500

Termination of Insurance: 65th birthday

Other Carrier Benefits

General Information

Eligibility

A person is eligible, and continues to be eligible, to be a member while he meets all of the following conditions:

1. You are actively working for a Participating Hospital belonging to the Council of Academic Hospitals of Ontario.
2. You regularly work for a Participating Hospital belonging to the Council of Academic Hospitals of Ontario at least 15 hours a week.
3. You are a resident of Canada.

Participation is compulsory.

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

Waiting Period - Nil

Enrolment

To enrol, you must submit a completed enrolment form.

Effective Date

Your insurance is effective on the date you become eligible.

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

Changes in Insurance

An increase in your benefits due to a salary change will be effective on the first of the month, unless you are not actively working on that day due to disease or injury.

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

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

Termination of Insurance

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

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

Other Carrier Benefits

Member Life Insurance Provision

Benefit

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

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Claims

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

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

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

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

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

At Termination

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

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

There are a number of rules and conditions in the group policy that apply to converting this insurance, including the maximum amount that can be converted. Please contact your employer for details about this Life conversion product or other products that may be available to you.

Respecting your privacy

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

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

Notes

This page has been provided to allow you to make notes regarding your Group Benefit Program, or how to best access your Group Benefits.

This image shows a full page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, typical of notebook paper. There are no margins, text, or other markings on the page.