Sun Life Financial

your group benefits

The Governors of the University of Alberta

Management and Professional Staff (MAPS)

Group Policy No. 25379
Effective October 15, 2024
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Table of Contents

Your Group Benefits Booklet

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.

The Governors of the University of Alberta self-insures all benefits. This means The Governors of the University of Alberta has the sole legal and financial liability for all benefits and funds the claims. With the exception of drugs on the *Prior Authorization Program*, Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

Your employer is there to help

Your employer 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

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 employer).

Summary of Benefits

Policy Number *25379*

Extended Health

Part	Benefit	Deductible		Reimbursement
		per person	per family unit	
A	Drug: Pay Direct	none	none	100%
B	Vision: $350*	none	none	100%
C	Hospital: ward to semi-private/ward to private**	none	none	100%
D	Supp. Health Care	none	none	100%
E	Out-of-Province Emergency and Travel Assistance	none	none	100%

*Maximum for eyeglasses/contact lenses, laser eye correction surgery and for the non-surgical treatment of keratoconus during a 24 month period (12 month period for a covered dependant under age 18).

**Hospital includes convalescent, acute and rehabilitation hospital. Rehabilitation hospital requires a physician's prescription and is reimbursed at 75%, limited to a maximum of $25,000 per person every 36 month period commencing the first applicable expense date.

Other maximums are listed under the appropriate Provision page.

Termination Age: member's retirement

Dental

Part	Benefit	Deductible per family unit	Reimbursement	Maximum
A	Diagnostic/Preventive	none	100%	none
B	Restorative	none	100%	none
C	Orthodontic*	none	75%	none
D	Periodontic	none	100%	none
E	Denture	none	75%	none
F	Bridge	none	75%	none
G	Crown	none	75%	none
H	Endodontic	none	100%	none

* **The Orthodontic benefit is for you and for each covered dependant.**

Termination Age: member's retirement

Dental Fee Guide: The applicable fee guide is the one in force on the day when and in the province where the expense is incurred or, for expenses incurred outside Canada, in the province of residence of the member. 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. For services provided by dental specialists, the fee guide for dental specialists will apply. For services provided by dentists, the fee guide for general practitioners will apply.

Health Spending Account

The benefit year is from January 1 to December 31.

Plan credits: $750 on the commencement of each benefit year

Termination Age: member's retirement

General Information

Eligibility

You are eligible, and continue to be eligible, to be a member while you meet all of the following conditions:

1. You are actively working for us.
2. You regularly work for us at least 20 hours each week.
3. You have been continuously employed by us at least as long as the waiting period.
4. 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 - none

You are eligible, and continue to be eligible, for dependant coverage while you meet all of the following conditions:

1. You are a member.
2. You have at least one dependant.
3. Your dependants are residents of Canada.

Definitions

Dependant

means your spouse or a dependent child of you or your spouse.

Dependent child

means a natural, adopted or step-child who is not married or in any other formal union recognized by law, who is entirely dependent on you for maintenance and support and who is

1. under 21 years of age,
2. under 25 years of age (26 years of age for the Extended Health Benefit for Québec residents only) and attending a college or university full-time, or
3. physically or mentally incapable of self-support and became incapable to that extent while entirely dependent on you for maintenance and support and while eligible under 1) or 2) above.

He, his and him

refer to both genders.

Spouse

means your spouse by marriage or under any other formal union recognized by law, or a person of the opposite or same sex who is living with and has been living with you in a conjugal relationship.

We, us and our

refer to The Governors of the University of Alberta.

Enrolment

To enrol, you must submit a completed enrolment form. If you have a dependant, request dependant coverage when you enrol.

Effective Date

Your coverage is effective on the date that you became eligible.

Your dependant coverage is effective on the latest of

- the date that you become eligible for dependant coverage, or
- the date that you request dependant coverage.

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

Comparable Coverage

If you are covered for comparable coverage under your spouse's plan, you may decline the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops you will be covered for the similar coverage provided by this plan.

If your dependant is covered for comparable coverage under another plan, you may decline the dependant coverage for the Extended Health/Dental coverage offered under this plan. If this comparable coverage stops, your dependants will be covered for the similar coverage offered under this plan.

The coverage that replaces the comparable coverage is effective on the date that the comparable coverage stops.

Termination of Coverage

Your coverage 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 plan terminates.

Extended Health Provision

Benefit

The Governors of the University of Alberta self-insures this benefit. This means that The Governors of the University of Alberta has the sole legal and financial liability for this benefit and funds the claims. With the exception of drugs on the *Prior Authorization Drug Program*, Sun Life provides administrative services only (ASO). This includes claims adjudication and claims processing. For drugs on the *Prior Authorization Drug Program*, Cubic Health administers this Program and directs Sun Life to process claims when the drug is eligible for reimbursement.

To qualify for the Extended Health coverage, you or your dependant must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

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

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for medically necessary services required for the treatment of disease or bodily injury. To determine the amount payable, the total amount of eligible expenses you claim will be adjusted as follows:

1. the maximums described throughout the extended health benefit provisions are applied,
2. then the deductible, which must be satisfied each calendar year, is subtracted, and
3. the reimbursement percentage is applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

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

Claims

A claim must be received, from active and terminated members, by Sun Life within 90 days from the end of the calendar year of which the expense is incurred.

For the assessment of a claim, itemized bills, attending physician statements or other necessary information are required.

If your physician is recommending medical treatment that is expected to cost more than $1,000, you should request pre-authorization to ensure that the expenses are covered.

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

Exclusions

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or a similar statute,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses for services and products, rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage,
- expenses for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with Government Programs*,
- expenses for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- expenses for services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards,
- expenses for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada),
- out-of-province expenses for elective (non-emergency) medical treatment or surgery.

Integration with Government Programs

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

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

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

At Termination

If you die, your covered dependant's Extended Health Benefits will be continued for 6 months, as long as the Extended Health provision remains in force. Your dependants must contact your employer to arrange the extension of coverage.

My Health CHOICE Coverage

If your coverage under this plan terminates because your employment has ended, you may purchase Sun Life's My Health CHOICE coverage. This coverage is different from your group plan.

To be eligible for My Health CHOICE coverage, you must:

- apply for My Health CHOICE coverage within 60 days after the termination of your coverage,
- be under age 75 on the date you apply, and
- be a resident of Canada and be covered under the provincial health plan.

My Health CHOICE coverage may also include Dental coverage if you were covered for both Extended Health Care and Dental Care benefits under this group plan, and both benefits terminated.

You may cover your spouse and dependents if those family members were covered under your group plan. Your spouse must be under age 75 on the date you apply for this coverage.

From time to time, Sun Life may review the eligibility requirements and, on the date you apply for My Health CHOICE coverage, they may be different from those listed in this booklet.

To apply for My Health CHOICE or if you have any questions, please call our Customer Solutions Centre at 1-877-893-9893.

Extended Health – Pay Direct Drug

Eligible Expenses

Eligible expenses are the reasonable and customary charges for the following items of expense, provided they are medically necessary for the treatment of disease or injury, prescribed by a physician or dentist and dispensed by a registered pharmacist or physician. Drugs covered under this benefit must have a Drug Identification Number (DIN) and be approved under *Drug evaluation*. There are additional eligibility requirements that apply to some drugs, see *Prior Authorization Drug Program* for details.

1. drugs which legally require a prescription.
2. life-sustaining drugs which may not legally require a prescription.
3. injectible drugs.
4. varicose vein injections, reasonable and customary limitations are not to apply,
5. administration of injections, reasonable and customary limitations are not to apply,
6. compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
7. muscle relaxants which may not legally require a prescription.
8. expenses for smoking cessation aids,
9. expenses for drugs used for the treatment of sexual dysfunction, limited to a maximum of $1,200 per calendar year,
10. expenses for contraceptives (oral and non-oral),
11. expenses for drugs used for the treatment of obesity, subject to prior approval (see *Prior authorization program* described below).

***Pharmaceutical services (rendered by pharmacists)* –** For members and insured dependants who live in Québec, Sun Life will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements

Smoking cessation products – For members and insured dependants who live in Québec, smoking cessation products are covered in accordance with the requirements under the Québec drug insurance plan.

***Québec drug insurance plan* –** For members and insured dependants who live in Québec, any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements

Drug evaluation

The following drugs will be evaluated and must be approved by Sun Life to be eligible for coverage:

1. drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017.
2. drugs covered under this plan and subject to a significant increase in cost.

Drug expenses are eligible for reimbursement only if incurred on or after the date of Sun Life's approval.

Sun Life will assess the eligibility of the drug based on factors such as:

- comparative analysis of the drug cost and its clinical effectiveness.
- recommendations by health technology assessment organizations and provinces.
- availability of other drugs treating the same or similar condition(s).
- plan sustainability.

Drug Substitution Limit

Charges in excess of the lowest priced equivalent drug are not covered, unless the physician or dentist has indicated no substitution on the prescription form.

Prior Authorization Drug Program

The Prior Authorization (PA) Drug Program requires a covered person to meet a defined set of evidence-based, clinical criteria related to a given medical condition before coverage of a specific PA Drug is approved.

A PA Drug is defined as a drug product that has an annual cost of $5,000 or more for a treatment period of one (1) year or less and which is typically prescribed by an appropriate specialist in a given therapeutic area. A PA Drug could also include specific products that cost less than $5,000 per year where there are safety concerns that can be mitigated with a PA process.

A PA Drug requires a covered person to provide written consent to an independent clinical case evaluator, Cubic Health, in order to obtain any relevant personal medical information from a covered person's health care professional team (i.e. physician(s), pharmacist(s), nurse practitioner(s), case manager(s), etc.) as needed to make a coverage decision.

A PA Drug will have a maximum initial approval period of one (1) year. Where applicable, that will be communicated at the time of any approval. A renewal form will need to be filled out prior to the end of the coverage period in order to be considered for an extension of the approval. An initial PA Drug approval for a given product does not guarantee approval at renewal time. Renewals are based on demonstrated safety and clinical effectiveness of the product for the covered person, and the covered person's appropriate adherence to therapy.

A specific PA Drug may not be covered for a given person if:

- it has been determined that the person has not attempted an adequate trial of clinically appropriate alternative therapies for the same condition.
- the requested dosing is clinically inappropriate.
- it is being used for an underlying condition that is not approved by Health Canada.
- the PA Drug or a clinically appropriate alternative is covered by a public program.
- it has been determined that the person has not attempted another medication for the same condition which is of comparable efficacy and safety but is more cost-effective.
- the specific PA Drug being requested has not received an unconditional recommendation for listing by the Canadian Agency for Drugs and Technologies in Health (CADTH) based on concerns around safety and/or clinical effectiveness and/or cost-effectiveness.

Cubic retains the right to require an adequate trial of clinically appropriate alternative therapies before a requested PA Drug is approved and reimbursed under the plan.

Once a decision has been rendered under the PA Drug Program, it cannot be appealed unless there has been a material change in the person's underlying medical condition that warrants reconsideration. An appeal does not automatically ensure approval.

If a PA Drug is approved, it will be subject to the prescription drug reimbursement level and all other conditions applicable to prescription drugs.

Grand-parenting of drugs reimbursed prior to March 1, 2021 – if a PA Drug was reimbursed under The Governors of the University extended health plan in the 6 month period prior to the effective date of this program, the covered person will automatically be grand-parented and will not be required to apply for prior authorization. However, if there is a requirement to change an existing PA Drug, or add another PA Drug to the covered person's medication regimen, the covered person will be required to apply for prior authorization for that drug.

Drug Utilization Review (DUR)

Sun Life provides a Drug Utilization Review (DUR) service to ensure the safe and effective use of drugs prescribed for you and your covered dependant. Your pharmacist will review an eligible drug against your past drug claims for possible harmful effects to your health, such as a severe drug interaction.

Other Health Professionals Allowed to Prescribe Drugs

Certain drugs prescribed by other qualified health professionals will be reimbursed the same way as if the drugs were prescribed by a physician or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Limitations and Exclusions

No benefit is payable for

1. the portion of expenses for which reimbursement is provided by a government plan,
2. expenses for drugs which, in Sun Life's opinion, are experimental,
3. expenses for dietary supplements, vitamins and infant foods,
4. expenses for drugs which are used for cosmetic purposes,
5. expenses for natural health products, whether or not they have a Natural Product Number (NPN),
6. expenses for drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility, and
7. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Vision Benefit

Definitions

Laser eye surgery
means the expenses incurred for laser eye surgery performed by an ophthalmologist licensed to practice ophthalmology, limited to the maximums and reimbursement percentage specified in the Summary of Benefits for the vision care benefit. A member or covered dependant who has received reimbursement for laser eye surgery will not be eligible for eyeglasses and contact lenses expenses during the same vision benefit period following the surgery.

Ophthalmologist
means a person licensed to practise ophthalmology.

Optometrist
means a member of the Canadian Association of Optometrists or of a provincial association associated with it.

Reasonable and customary charges
mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense:

1. eye examinations by an ophthalmologist or optometrist limited to one examination per person in a calendar year.
2. Eyeglasses, laser eye surgery and contact lenses and repairs to them that are necessary for the correction of vision and are prescribed by an ophthalmologist or optometrist, limited to the maximum specified in the Summary of Benefits for eligible expenses incurred during a 24 month period (12 month period for a covered dependant under age 18).
3. eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure or the treatment of keratoconus, limited to a lifetime maximum of $200 for the non-surgical treatment of keratoconus for you and for each covered dependant and a maximum of $200 for expenses incurred within six months of each surgical procedure.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Hospital Benefit

Definitions

Hospital
means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Reasonable and customary charges
mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Eligible Expenses

Eligible expenses mean reasonable and customary charges for accommodation in a hospital, limited to the difference between the charges for semi-private and private room for each day of hospitalization.

Exclusions

No benefit is payable for

1. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Supplementary Health Care Benefit

Definitions

Acupuncturist
means a person who is listed on the appropriate provincial registry.

Athletic Therapist
means a person licensed by the appropriate provincial licensing authority as an athletic therapist, or a person who is an active member of the Canadian Athletic Therapist Association (CATA) or of a provincial association approved by Sun Life.

Audiologist
means a member of the Canadian Speech & Hearing Association or of any provincial association affiliated therewith.

Chiropodist, Podiatrist
means a person licensed by the appropriate provincial licensing authority.

Chiropractor
means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.

Hospital
means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury, on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons when approved by Sun Life. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

Midwife
means a person who is listed on the appropriate provincial registry.

Naturopath
means a member of the Canadian Naturopathic Association or any provincial association affiliated with it.

Occupational Therapist
means a person licensed by the appropriate provincial licensing authority.

Osteopath
means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association or a person who holds a Diploma in Osteopathic Manual Practice (DOMP).

Physiotherapist
means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.

Psychologist
means a permanently certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.

Reasonable and customary charges
mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Registered Massage Therapist
means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications Sun Life determines to be comparable with those required by a licensing body.

Registered Nurse, Registered Nursing Assistant, Certified Nursing Assistant, Licensed Practical Nurse, Registered Practical Nurse
means a nurse, nursing assistant or practical nurse or certified nursing assistant who is listed on the appropriate provincial registry.

Respiratory Therapist
means a person who is listed on the appropriate provincial registry.

Social Worker
means a person who holds a Master of Social Work (MSW) degree from an accredited university.

Speech Language Pathologist
means a person who holds a master's degree in Speech Language Pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it.

Eligible Expenses

To be eligible, the expenses must be medically necessary for the treatment of disease or bodily injury and prescribed by a physician.

Eligible expenses are the reasonable and customary charges for the items of expense listed below.

1. the services of a registered nurse (R.N.), registered nursing assistant (R.N.A.), certified nursing assistant (C.N.A.), licensed practical nurse (L.P.N.) or registered practical nurse (R.P.N.) when provided in the patient's home, including services of an R.N.A. in a hospital, limited to a combined maximum, with hospice coverage under the Extended Health – Supplementary Hospital benefit, of $25,000 every 3 years. To qualify as an eligible expense, the patient's treatment must require the level of expertise of an R.N., R.N.A., C.N.A., L.P.N., or R.P.N.

2. the services of the following practitioners, limited to a maximum of $75 per visit up to a maximum of $1,800 for each person per calendar year for all practitioners combined.

    - an acupuncturist*,
    - an athletic therapist,
    - a physiotherapist*,
    - a registered massage therapist*, limited to a calendar year maximum of $600 for each person within the $1,800 calendar year maximum,

- a psychologist*,
- a social worker*,
- a chiropractor*, including x-ray, and
- an osteopath*, including x-ray.

* physician's prescription not required.

3. the services of a speech therapist, limited to a maximum of $1,000 for each person per calendar year. A physician's prescription is not required.

4. the services of a podiatrist or chiropodist. X-rays are limited to &5 per occurrence. A physician's prescription is not required. Podiatrist surgery is limited to $600 per person per calendar year.

5. the services of a naturopath, limited to $75 per visit up to a maximum of $600 per person per calendar year. A physician's prescription is not required.

6. the services of a midwife, after the provincial maximum has been reached, limited to a maximum of $2,500 for each person per pregnancy. A physician's prescription is not required.

7. the services of an occupational therapist, limited to a maximum of $1,000 for each person per calendar year. A physician's prescription is not required.

8. the services of an audiologist. A physician's prescription is not required.

9. the services of a respiratory therapist, limited to a maximum of $1,000 for each person per calendar year. A physician's prescription is not required.

10. the services of a dental surgeon, including dental prosthesis, required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means, provided the services are performed within 6 months of the accident but excluding services required in conjunction with such fracture or injury due to a condition that existed before the accident. A physician's prescription is not required.

11. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

12. emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, and, if the patient requires the services of a registered nurse during the flight, the services and return air fare for a registered nurse.

13. reasonable and customary charges for orthopaedic shoes, orthopaedic modifications to shoes and non custom made shoes (prefabricated shoes or extra depth) when they are required for the correction of deformity of the bones and muscles and provided they are not solely for athletic use and are prescribed by a physician, podiatrist, chiropodist or chiropractor, limited to a maximum of one pair per person per calendar year.

14. orthotics, when they are required for the correction of deformity of the bones and muscles and are prescribed by a physician, podiatrist, chiropodist or chiropractor, limited to 2 pairs up to a maximum of $500 per pair per year.

15. hearing aids and repairs to them, excluding batteries, limited to a maximum of $2,000 for each ear for eligible expenses every 3 calendar years combined with the services of an audiologist. A physician's prescription is not required.

16. constant positive airway pressure machine (CPAP) limited to a maximum of $2,000 every 5 years. Supplies are limited to once every 12 months and are not included in the $2,000 maximum.

17. Eyeglasses and contact lenses certified by an ophthalmologist as necessary due to a surgical procedure for the treatment of keratoconus, limited to a maximum of $350 per calendar year per person, reimbursed at 50%.

18. rental or purchase, at our option, of transcutaneous electronic nerve stimulator (TENS), reimbursed at 50% and limited to a lifetime maximum of $1,000.

19. mammary prosthesis and surgical brassieres, following a mastectomy, limited to a maximum of $500 per calendar year.

20. elastic support stockings, including pressure gradient hose, limited to 3 pairs per calendar year.

21. stump socks, limited to 5 pairs per calendar year.

22. insulin pump and maintenance, limited to a lifetime maximum of $2,000.

23. infusion pump, limited to a lifetime maximum of $2,000.

24. medijector.

25. wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a maximum of $600 for each person per calendar year.

26. trusses and crutches.

27. plaster of paris or fibreglass casts.

28. braces, provided they are not solely for athletic use.

29. artificial limbs or other prosthetic appliances.

30. oxygen.

31. blood/plasma.

32. diagnostic laboratory and x-ray examinations.

33. blood glucose monitors.

34. INR machine.

35. speech aids, reimbursed at 50%.

36. rental, or purchase at our option, of medically necessary durable equipment that meets the patient's basic medical needs and is approved by Sun Life. If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets the patient's basic medical needs. Eligible durable equipment includes, but is not limited to, items such as:

    - wheel chairs,
    - wheel chair repairs,
    - walkers,

37. Unless otherwise listed above, reasonable and customary chares for medically necessary durable equipment that meets the patient's basic medical needs and is approved by Sun Life. Reimbursement at 50% and limited to $1,000 per item.
    Such items are, but not limited to:

    - maximist/nebulizer,
    - cushion Roho/combi,
    - extremity pump,
    - mechanical hydraulic lift.

38. cannabis for medical treatment, if the information provided by the covered person and the attending physician on the *Prior Approval Form for Medical Cannabis* meets clinical criteria, including symptoms, for conditions approved by Sun Life. If the covered person submits a claim for medical cannabis and has not been pre-approved, the claim will be declined. Medical cannabis must be dispensed according to Health Canada's regulations.

39. the following hospital and medical services which are not offered in the province of residence and are performed following written referral by the attending physician in the patient's province of residence, reimbursed at 100%.

    a. public ward accommodation and auxiliary hospital services in a general hospital, after deducting the amount payable by a government plan.
    b. services of a physician limited to, after deducting the amount payable by a government plan, the level of physicians' charges in the patient's province of residence.

    Items of expense incurred outside Canada are eligible only if they are not offered in any province in Canada.

40. continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, reimbursed at 90%, limited to a combined maximum of $4,000 in a calendar year. Sun Life must be provided with a physician's note confirming the diagnosis

Exclusions

No benefit is payable for

1. expenses for the services of a homemaker,
2. expenses for items purchased solely for athletic use,
3. dental expenses, except those specifically provided under Eligible Expenses for treatment of accidental injuries to natural teeth,
4. utilization fees which are imposed by the provincial health care plan for the use of a service,
5. expenses incurred under any of the conditions listed on the Extended Health Provision page as an Exclusion.

Extended Health – Out-of-Province Emergency and Travel Assistance Benefit

To be covered for this benefit, you and your covered dependant must have provincial health care coverage. Expenses for hospital/medical services and travel assistance benefits are eligible if

1. they are incurred as a result of emergency treatment of a disease or injury which occurs outside your home province,
2. they are medically necessary, and
3. they are incurred due to an emergency which occurs during the first 180 days of travelling on vacation or business outside your home province. Your 180 days of coverage starts on the day you or your covered dependant departs from your home province.

Definitions

Emergency
means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a physician.

Emergency services
mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When you or your covered dependant have a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to leaving your province of residence.

Family member
means you or your covered dependant.

Reasonable and customary charges
mean those which are usually made to a person without coverage for the items of expense listed under Eligible Expenses and which do not exceed the general level of charges in the area where the expense is incurred.

Relative
means your spouse, parent, child, brother or sister.

Emergency Services

At the time of an emergency, the family member or someone with the family member must contact Sun Life's Emergency Travel Assistance (ETA) provider. All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Sun Life's ETA provider prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Sun Life's ETA provider cannot be made before services are provided, contact with Sun Life's ETA provider must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when the family member is medically stable to return to his province of residence.

Emergency Services Excluded from Coverage

Any expenses related to the following emergency services are not covered:

1. services that are not immediately required or which could reasonably be delayed until the family member returns to his province of residence, unless his medical condition reasonably prevents him from returning to his province of residence prior to receiving the medical services.
2. services relating to an illness or injury which caused the emergency, after such emergency ends.
3. continuing services arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Sun Life's ETA provider, based on available medical evidence, determines that the family member can be returned to his province of residence, and he refuses to return.
4. services which are required for the same illness or injury for which the family member received emergency services, including any complications arising out of that illness or injury, if the family member had unreasonably refused or neglected to receive the recommended medical services.
5. where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Non-Emergency Services

Out-of-province and out-of-Canada non-emergency coverage for physician services as well as in-patient and out-patient services incurred outside the member's province of residence and Canada. Reimbursement will be 100%, limited to an annual maximum of $5,000 per person. Expenses must first be assessed by the provincial plan. Out-of-province/Canada emergency and non-emergency expenses must be incurred within 180 days of departure from persons province of residence.

Eligible Expenses for Hospital/Medical Services

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services, less the amount payable by a government plan:

1. public ward accommodation and auxiliary hospital services in a general hospital,
2. services of a physician,
3. economy air fare for the patient's return to his province of residence for medical treatment,
4. licensed ground ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation,

5. emergency air ambulance service to the nearest hospital equipped to provide the required treatment, or to Canada, when the patient's physical condition prevents the use of another means of transportation, and if the patient requires a registered nurse during the flight, the services and return air fare for the registered nurse.

Expenses that are included as Eligible Expenses under Drug, Vision, Hospital or Supplementary Health Care benefits are also eligible while you or your covered dependant is travelling outside Canada. These expenses are subject to the deductibles and reimbursement percentages listed under the appropriate benefit in the Summary of Benefits.

Eligible Expenses for Travel Assistance Benefits

Eligible expenses mean reasonable and customary charges for the following items of expense incurred for emergency services:

1. family assistance benefits, which include reimbursement for the cost of:
    a. return transportation for covered dependent children who are under the age of 16, or who are handicapped, if they are left unattended because you or your spouse is hospitalized outside your province of residence. If necessary, an escort will be provided to accompany the dependent children. The maximum payable for the return transportation is a one-way economy fare for each dependent child.
    b. return transportation for family members, if the hospitalization of a family member prevents them from returning home on the originally scheduled, pre-paid transportation, and consequently requires them to purchase new return tickets. The extra cost of each return fare is payable to a maximum of a one-way economy fare, less any amount reimbursed for the unused, return tickets.
    c. visit of one relative, if a family member is hospitalized for more than 7 days while travelling without a relative. This includes meals and accommodation up to a maximum of $150 per day, and round-trip economy transportation, for one relative. These expenses are also covered when it is necessary for a relative to identify a deceased family member before the release of his body.
    d. meals and accommodation up to a maximum of $150 per day per family, if a trip is extended because a family member is hospitalized.

The combined maximum amount payable for the above family assistance benefits is $5,000 for one travel emergency.

2. return of a deceased family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to his province of residence. The maximum amount payable for the preparation and return of the deceased is $5,000. Preparation of the deceased includes expenses for cremation at the place of death. Return of the deceased **includes** a basic shipping container, but **excludes** expenses for burial, such as burial caskets and urns.
3. return of a vehicle. If a family member is unable to operate a vehicle (owned or rented) because he is being returned to Canada for medical treatment, Sun Life will administer reimbursement of the cost of returning this vehicle to his province of residence, or the nearest appropriate rental agency. This benefit is also payable in the event of a family member's death. The maximum amount payable for returning the vehicle is $500.

Travel Assistance Services

Out-of-province and around-the-world services are provided through Sun Life's ETA provider, a company specializing in emergency medical assistance for travellers. By calling the 24 hour helpline, Sun Life's ETA provider will be able to provide you and your covered dependants with the following emergency assistance services during the first 180 days of travel:

1. physician and hospital referrals,
2. on-going monitoring of medical treatment if a family member is hospitalized,
3. coordination of transportation arrangements via ground or air ambulance if it is medically necessary to return a family member to Canada or transfer him to another hospital that is equipped to provide the required treatment,
4. payment assistance for hospital/medical expenses,
5. legal referrals,
6. a telephone interpretation service,
7. a message service for you, your family, friends and business associates.

Emergency Payment Assistance

Eligible Hospital/Medical Expenses:

To ensure payment of these expenses,

1. **Call the 24 hour helpline immediately.** If you are physically unable to call the helpline yourself, then have a family member, travelling companion or medical personnel call for you. Simply showing your Sun Life Travel card to a doctor, nurse or hospital personnel will **NOT** ensure payment of these expenses.
2. Sun Life's ETA provider will verify your extended health coverage and provincial health care coverage so payments can be arranged on behalf of you or your covered dependant.
3. You will be required to sign an authorization form allowing Sun Life's ETA provider to recover any amounts payable by the provincial health care plan.
4. For expenses that require a percentage paid by you, or that are not covered under this plan or the provincial health care plan, you must reimburse Sun Life for the excess amount of the payment.
5. If you receive any subsequent bills for these expenses, please forward them to Sun Life's ETA provider and they will coordinate payments with the provincial health care plan and Sun Life.

24 Hour Helpline

If emergency assistance is needed, a 24 hour helpline is available. Multilingual coordinators at Sun Life's ETA provider can access a worldwide network of professionals who offer help with medical, legal, and other travel-related emergencies.

The 24 hour helpline can assist you and your covered dependant if you have lost your passport or visa, if you need to find a local legal advisor, or if you require telephone interpretation services. You can also call the helpline and leave important messages for family, friends or business associates; likewise, they can call the helpline and leave messages for you while you travel. Sun Life's ETA provider will hold such messages for 15 days.

When calling the 24 hour helpline, please be ready to state your Plan No., Certificate No., ID No., and Provincial Medical Insurance Plan/Health Card Number.

Please consult the telephone numbers on your Travel card.

Exclusions and Limitations

No benefit is payable for

1. expenses incurred by you or your covered dependant due to an emergency which occurs more than 180 days after departure from your province of residence,
2. expenses incurred on a non-emergency or referral basis unless specifically listed as an eligible expense,
3. expenses incurred under any of the conditions listed as an Exclusion in the Extended Health Provision.

If you are covered as a retired employee, you and your covered dependants must return to your province of residence for at least 30 consecutive days before becoming eligible for another 180 days of coverage.

Due to conditions such as war, political unrest, epidemics, and geographic inaccessibility, emergency assistance services may not be available in certain countries. For more information on travelling conditions and the availability of Sun Life's ETA provider services in a particular country, please call the appropriate 24 hour helpline.

Neither Sun Life nor Sun Life's ETA provider is responsible for the availability, quality or results of the medical treatment received by the family member, or for the failure to obtain medical treatment.

Dental Provision

Benefit

The Governors of the University of Alberta self-insures this benefit. This means that The Governors of the University of Alberta has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

1. the deductible, which must be satisfied each year, is subtracted,
2. the reimbursement percentage is applied, and
3. the maximums specified in the Summary of Benefits are applied.

The intentional omission, misrepresentation or falsification of information relating to any claim constitutes fraud.

Sun Life reserves the right to refuse any assignment of benefits under this provision.

Alternate procedures

For an implant related crown or prosthesis, Sun Life will pay the benefit that would have been payable under this plan for a tooth supported crown or a non implant related prosthesis, respectively. Sun Life 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.

Co-ordination of Benefits

If you or your dependants are covered under this plan and another plan, Sun Life will co-ordinate benefits under this plan 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 co-ordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a co-ordination of benefits clause.

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

Following payment under another plan, the amount of benefit payable under this plan will not exceed the total amount of eligible expenses incurred less the amount paid by the other plan.

Where both plans contain a co-ordination 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:

1. 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.
2. the plan where the person is covered as a dependant.

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

1. the plan where the dependent child is covered as an employee,
2. the plan where the dependent child is covered under a student health or dental plan provided through an educational institution,
3. the plan of the parent with the earlier birth date (month and day) in the calendar year,
4. 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 dependent child, in which case the following order applies:

1. the plan of the parent with custody of the dependent child,
2. the plan of the spouse of the parent with custody of the dependent child,
3. the plan of the parent not having custody of the dependent child,
4. the plan of the spouse of the parent not having custody of the dependent child.

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

Claims

A claim must be received, from active and terminated members, by Sun Life within 90 days from the end of the calendar year of which the expense is incurred.

For the assessment of a claim, itemized bills, commercial laboratory receipts, reports, records, pre-treatment x-rays, study models, independent treatment verification or other necessary information may be required.

If your dentist has recommended dental treatment that is expected to cost more than $500, you must have your dentist prepare a pre-treatment plan.

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

Exclusions and Limitations

No benefit is payable for

- expenses for which benefits are payable under a Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation,
- expenses incurred due to civil disorder or war, whether or not war was declared,
- expenses 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.

Anaesthesia and laboratory procedure charges must be completed in conjunction with other services and the amount payable will be limited to the reimbursement percentage of the services they are being performed in conjunction with. Laboratory charges are also limited to 66 2/3% of the fee for the procedure in the Dental Fee Guide shown on the Summary of Benefits.

At Termination

If you die, your covered dependant's Dental Benefits will be payable for eligible expenses incurred by your covered dependant within 6 months following the date the member died, provided this provision continues in force. Your dependants must contact your employer to arrange the extension of coverage.

Dental Provision – Diagnostic/Preventive Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) examination and diagnosis:

- oral examination (once every 36 months),
- recall examination (twice every 12 months),
- limited periodontal examination (twice every 12 months),
- special oral examination,
- treatment planning,
- minor emergency treatment,
- consultation,
- house call, institutional call, office visit and after hours calls,

(b) tests and laboratory examinations:

- microbiological,
- biopsy of oral tissue,
- cytological,
- pulp vitality tests,

(c) radiographs:

- complete series (once every 24 months),
- periapical,
- occlusal,
- bitewing (twice every calendar year for covered dependant children under age 16 and twice every 12 month period for any other person),
- extraoral,
- skull and facial bone,
- sialography,
- radiopaque dyes to demonstrate lesions,
- temporomandibular joint dysfunction,
- panoramic (once every 36 months),
- interpretation of radiographs received from another source,

(d) preventive services:

- dental polishing (twice every 12 months),

- preventive scaling,
- topical application of fluoride phosphate (twice every 12 months for a person under age 16 and once 12 month period for any other person),
- oral hygiene instruction (once every 12 months),
- interproximal discing,
- pit and fissure sealants (for persons under 16 years of age),

(e) control of oral habits:

- appliances,

(f) space maintainers (for persons under 18 years of age)

(f) relining and rebasing of dentures

(g) laboratory procedures

(h) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions, including simple extractions)

- general anaesthesia,
- facilities,
- deep sedation,
- conscious sedation

Rebasing, relining of dentures or tissue conditioning will be covered providing 1 year has elapsed since installation of the denture. Subsequent treatments are allowed every 36 consecutive months, as required.

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses replacement of space maintainers which have been lost, stolen or mislaid,
3. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Restorative Benefit

Eligible Expenses

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) restorations:

- caries and trauma control,
- amalgam,
- acrylic or composite resin,

(b) denture repairs and additions

(c) surgical services:

- uncomplicated removals,
- surgical removals and repositioning,

(d) laboratory procedures

(e) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions, including simple extractions)

- general anaesthesia,
- facilities,
- deep sedation,
- conscious sedation

The addition of teeth to an existing partial denture is an eligible expense for you and for each covered dependant.

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses for replacement of dentures and addition of teeth to existing dentures except as provided under Eligible Expenses,
4. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Orthodontic Benefit

Eligible Expenses

You will be reimbursed when you submit proof to Sun Life that you or your covered dependant has incurred any of the eligible expenses for necessary dental services performed by a dentist, a dental hygienist or a denturist. To determine the amount payable, the total eligible expenses claimed are adjusted as follows:

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) observation, adjustment:

- oral examination,
- cephalometric radiographs,
- diagnostic photographs,
- diagnostic cast,
- surgical services,
- observation, adjustment,
- repairs, alterations,
- active appliances for tooth guidance or uncomplicated tooth movement,
- retention appliances,

(b) comprehensive treatment

(c) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions including simple extractions)

- general anaesthesia,
- deep sedation,
- conscious sedation,

(d) laboratory procedures

Exclusions

No benefit is payable for:

1. expenses for replacement of orthodontic appliances which have been lost, stolen or mislaid.
2. expenses incurred for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
3. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Periodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) periodontics:

- non surgical services,
- occlusal adjustment/equilibration (not exceeding 8 time units per lifetime),
- scaling and root planing (not exceeding 16 time units per year),
- surgical services
- post-surgical treatment,
- post treatment evaluation,
- adjunctive procedures

(b) major surgery:

- exposure of teeth,
- alveoloplasty,
- surgical excision,
- tumors,
- enucleation of cyst,
- surgical incision,
- extraoral abscesses,
- fractures and reductions,
- lacerations,
- frenectomy,
- dislocations,
- miscellaneous surgical services

(c) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions including simple extractions)

- general anaesthesia,
- deep sedation,
- conscious sedation,

(d) laboratory procedures

If scaling treatment is covered under both preventive and periodontic services, we will determine whether such treatment is payable under the preventive or periodontic services based on the following:

- Scaling treatment shall be considered preventive scaling provided the charge for such treatment is for less than 2 units of time.
- Scaling treatment shall be considered periodontal scaling provided the charge for such treatment is for 2 or more units of time.

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses for replacement of periodontal appliances which have been lost, stolen or mislaid,
3. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
4. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Denture Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) partial and complete dentures:
- complete dentures,
- partial dentures,

(b) remakes and adjustments:
- adjustment to dentures,
- remake partial dentures,

(c) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions including simple extraction)s
- general anaesthesia,
- Deep sedation,
- Conscious sedation

(d) laboratory procedures

Replacement of an existing denture or bridgework with a denture, is an eligible expense if the replacement is required to replace an existing denture which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

If the existing denture is an immediate or transitional denture and replacement by a permanent denture is required, the permanent denture must be replaced within 12 months from the date of installation of the immediate or transitional denture. If the immediate or transitional denture is not replaced within 12 months of installation, such denture will be considered a permanent denture. This provision will not apply in the case of accidental injury involving a Child under age 18.

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses for replacement dentures which have been lost, stolen or mislaid,
3. expenses for prosthetic devices which are ordered while you or your covered dependant is covered under this benefit but are installed after termination of this benefit,
4. expenses for replacement of dentures and addition of teeth to existing dentures except as provided under Eligible Expenses,
5. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Bridge Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) fixed bridgework:
- bridge pontics,
- retainers,
- other prosthetic services

(b) repairs and adjustments:
- repairs to bridges,
- porcelain repairs

(c) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions including simple extractions)
- general anaesthesia,
- deep sedation,
- conscious sedation,

(d) laboratory procedures

Replacement of an existing denture or bridgework with bridgework is an eligible expense if the replacement is required to replace an existing denture or bridgework which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original denture or bridgework.

The addition of teeth to existing bridgework is an eligible expense for you and for each covered dependant.

Coverage for bridgework involving one or more permanent molars is limited to the cost of a full metal pontic or retainer.

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while you or your covered dependant is covered under this benefit but are installed after termination of this benefit,
4. expenses for replacement of bridgework and addition of teeth to existing bridgework except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Crown Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) crowns, inlays, onlays:
- inlay and only restorations,
- crowns,
- other restorative services,
- prefabricated restorations (once per tooth every 60 months),

(b) repairs and adjustments:
- porcelain repairs,
- recementing crowns,

(c) examinations:
- oral examination,
- diagnostic casts,

(d) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions including simple extractions)
- general anaesthesia,
- deep sedation,
- conscious sedation

(e) laboratory procedures

Replacement of an existing crown, inlay or onlay is an eligible expense if the replacement is required to replace an existing crown, inlay or onlay which was installed at least 5 years before the replacement, limited to a maximum eligible expense of the value and quality of the original crown, inlay or onlay.

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses for crowns and onlays, placed on a tooth not functionally impaired by incisal angle or cuspal damage,
3. expenses for prosthetic devices which are ordered while you or your covered dependant is covered under this benefit but are installed after termination of this benefit,
4. expenses for replacement of crowns, inlays or onlays except as provided under Eligible Expenses,
5. expenses for permanent splinting,
6. expenses for full mouth reconstructions, for vertical dimension correction or for correction of temporomandibular joint dysfunction,
7. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Dental Provision – Endodontic Benefit

Eligible Expenses

Eligible expenses mean reasonable and customary charges for the following items of expense -

Procedures

(a) endodontics:
- carries, trauma control,
- pulp capping
- pulpotomy,
  root canal therapy,
- apical services,
- other endodontic procedures
- emergency procedures

(b) anaesthesia (if performed in conjunction with complex oral surgery, complex periodontal surgery and all extractions including simple extractions)
- general anaesthesia,
- deep sedation,
- conscious sedation,

(c) laboratory procedures

Exclusions

No benefit is payable for:

1. expenses for cosmetic services,
2. expenses incurred under any of the conditions listed on the Dental Provision page as an Exclusion or Limitation.

Health Spending Account

General Description of the Benefit

The Governors of the University of Alberta self-insures this benefit. This means that The Governors of the University of Alberta has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

Your Health Spending Account coverage pays for services or supplies described in this section under Eligible expenses.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependant are also covered. Coverage applies only to expenses incurred after the member becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependant is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

How your Health Spending Account Works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account as specified in the Summary of Benefits.

Each time you submit a Health Spending Account claim, either for yourself or for a dependant, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one benefit year cannot be covered by credits received in the following benefit year.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year following the benefit year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Benefits for Dependants After Termination

The Health Spending Account is set up under the member's name, and there cannot be any continuation of coverage for dependants after the member's death. Only expenses incurred before the member's death can be covered under the member's Health Spending Account.

Eligible Expenses

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act of Canada **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act of Canada is changed, this plan is automatically updated to reflect the changes.

Drugs

- drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses

- eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

Deductibles and coinsurances

- deductible and coinsurance amounts under medical or dental plans.

Licensed practitioners (fee for services)

- acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapeutists.

Dental care

- preventative, diagnostic, restorative, orthodontic and therapeutic care.

Attendant care

- remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months.
- remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.

Facilities

- amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future.
- payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.

Hospitals

- payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.
- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of $1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.

- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
- costs of medical services and supplies outside of the province of residence.
- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.

- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
  - equivalent medical services are not available locally.
  - the route is reasonably direct.
  - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Co-ordination of Benefits

If you or your eligible dependants have coverage under another plan, you should submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

Claims

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

In order for you to receive benefits, whether you are an active or terminated member, we must receive the claim no later than 90 days after the end of the benefit year during which you incur the expenses.

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

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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).