Randstad Affiliation Plan Extended Health Care and Dental Insurance Policy

Basic plan

Sun Life Financial

Sun Life Assurance Company of Canada agrees with you, the policy owner, to pay the benefits of this policy according to its terms and conditions.

In this document, you and your mean the owner of this policy.
We, us, our, and the company mean Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Signed at Toronto, Ontario

Dean Connor
President and Chief Executive Officer
Sun Life Assurance Company of Canada

Dana Easthope
Vice-President, Associate General Counsel and Corporate Secretary
Sun Life Assurance Company of Canada

Please read your policy carefully. If you change your mind, you may send us a written request to cancel your policy within 30 days of receiving it and we will refund any amount paid to us.

If you have any questions or require more information, please contact us at:

Sun Life Assurance Company of Canada
225 King St. W.
7th Floor
Toronto, ON M5V 3C5

1 800 669 7921

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Basic plan summary

Benefit	Reimbursement	Maximum per person
Drug	60%	$750 in a calendar year
Extended health	60%	Described in the *Extended health provision*
Preventive dental	60%	$500 in a calendar year

Note:
We will **only** reimburse medical expenses that are not covered by the insured person's provincial health care plan.

Drug
The amount we pay for the dispensing fee reimbursement is 100 per cent but is limited to a maximum of $5 per prescription.

Waiting period
Dental
An insured person becomes eligible for the preventive dental benefit three months after the effective date of this policy.

General provisions

Definitions

Acupuncturist	a person who is listed on the appropriate provincial registry.
Calendar year	January 1 to December 31.
Chiropodist/ Podiatrist	a person licensed by the appropriate provincial licensing authority to practice.
Chiropractor	a member of the Canadian Chiropractic Association or of a provincial association affiliated with it.
Dental fee guide	the current fee guide for general practitioners approved by the dental association in the province where the expense was incurred. When a dental fee guide is not published for a given year, "dental fee guide" means an adjusted fee guide established by us.
Dentist	a person licensed to practice dentistry by the provincial licensing authority.
Emergency	a sudden, unexpected occurrence of an acute illness or accidental injury requiring immediate, medically necessary treatment prescribed by a physician which cannot be delayed until the insured person returns to their province of residence.
Evidence of insurabililty	written proof that a proposed insured person meets our underwriting requirements. Evidence of insurability submitted to us is at the proposed insured person's expense.
Hospital	a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. Hospital does not include a nursing home, rest home, home for the aged, or chronically ill, residential and long term care centres, sanatorium, convalescent hospital, unless provided for in the *Semi-private hospital room provision*, or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital. If convalescent hospital is covered, we consider it to be a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. It does not include hospital accommodation for custodial care.
Insured person	a person accepted by us to be insured under this policy and who meets and continues to meet all of the eligibility requirements.
Lifetime maximum	the maximum amount we will pay for each insured person, while this policy is in effect.
Naturopath	a member of the Canadian Naturopathic Association or any provincial association affiliated with it.
Nurse	an out-of-hospital private duty nurse, when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse who is licensed, certified or registered in the province where the insured person lives and who does not normally live with the insured person and includes a registered nurse (RN), registered nursing assistant (RNA), certified nursing assistant (CNA), licensed practical nurse (LPN) or a registered practical nurse (RPN).
Osteopath	a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association.
Paradental practitioner	a person licensed by the appropriate provincial authority to work as a practitioner fitting dentures for, and supplying dentures directly to, the public.

Physician	a doctor of medicine (M.D.) licensed to practice medicine.
Physiotherapist	a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.
Policy anniversary	the month and day every year that is the same date as your policy date.
Psychologist	a certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.
Reasonable and customary charges	for *dental professional fees*, fees which are usually charged to a person without insurance and which are not greater than the fees in the dental fee guide. for *health expenses and dental laboratory charges*, mean amounts which are usually charged to a person without insurance and are not greater than the general level of charges in the area where the expenses are incurred.
Registered massage therapist	a person licensed by the appropriate provincial licensing body to practice massage therapy, or in the absence of a provincial licensing body, a person whose qualifications meet those required by a licensing body to practice massage therapy.
Registered pharmacist	a person who is licensed to practice pharmacology and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.
Speech language pathologist	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.

The Policy

This policy, which includes the application, the *Policy particulars* page and any amendment agreed to in writing, may not be changed or any provisions waived unless agreed to in writing by our officers authorized to sign policies.

The currency of this policy is Canadian.

If you or another insured person fail to tell us every fact material to the insurance, or misrepresent those facts, we may void the insurance.

Statements made on the application or on an evidence of insurability form, which are fraudulent, or a misstatement of age, may be contested at any time. Other statements are incontestable two years after the statements are made.

Premiums

The premium is determined according to the age of each insured person and the province where they live. If a change in age puts the insured person into another rate category, premiums are adjusted at the next policy anniversary. If an insured person changes the province where they live, premiums are adjusted according to the rates of the new province of residence and are effective on the date of the change.

We have the right to change your premium. We will give you 30 days written notice before the change is made.

Grace period

The grace period is 31 days for the payment of premiums and is allowed for each premium except the first. During the grace period, insurance remains in force and premiums continue to be payable by you.

We will terminate the policy when payment has not been made before the end of the grace period. We will send you written notice of termination. Any claims for expenses incurred after the policy has terminated are not eligible for payment.

Eligibility requirements

To be eligible, and continue to be eligible for coverage under this policy, a person must be:

- a resident of Canada,
- covered under provincial health insurance,
    - Quebec residents must also have and continue to have health and drug coverage through a group benefit plan or through Régie de l'assurance maladie du Québec (RAMQ). A person not covered under a group benefit plan or through RAMQ, is not eligible for coverage under this policy.
- related to you in one of the following ways:
    - legally married to you or in a civil union,
    - living with you in a conjugal relationship and represented as your spouse or partner, or
    - a child born to you, adopted by you, or a step child, who is unmarried and entirely dependent on you for maintenance and support and who is also:
        i) under 21 years of age, or
        ii) under 25 years of age and attending a college or university full time, or
        iii) physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on you while eligible under i) or ii).

It is your responsibility to tell us when an insured person no longer meets the eligibility requirements.

Changes

Changing plan type
You may apply at any time to change your existing plan type (basic, standard or enhanced) to any other plan type we offer at the time you apply for the change. You must apply in writing. We will require new evidence of insurability from all insured persons. If your application is approved, the change to your plan type takes effect on the date we determine.

Adding an insured person
Child
You may apply in writing to add a child as an insured person under this policy. This change takes effect on the later of the date we approve your request or the beginning of the next monthly coverage period for your policy.

We will add your newborn children without evidence if you ask us to add them within 30 days of their birth.

For any child you ask us to add, we may require you to prove the child's relationship to you. We will also tell you if you need to provide evidence of insurability for the child you want to add who is age 31 days or older.

You may apply to add any child who is unmarried and entirely dependent on you for maintenance and support and is either born to you, adopted by you, or is a stepchild and is:

i) under 21 years of age, or
ii) under 25 and attending college or university full time, or
iii) physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on you for maintenance and support while eligible under i) or ii).

Other eligible persons
You may ask us to add a person to the list of insured persons. You must make this request in writing. The person must meet our eligibility requirements and give evidence of insurability satisfactory to us. This change takes effect on the later of the date we approve your request or the beginning of the next monthly coverage period for your policy.

Removing an insured person
If you ask us in writing, we will remove an insured person from this policy. This change takes effect at the beginning of the next monthly coverage period for your policy.

Your right to cancel this policy

You may cancel this policy at any time by sending a written request to the address shown at the beginning of the policy. We must receive a minimum of ten days advance written notice of termination.

Claims

We must receive your claim within 12 months of the date the eligible expense is incurred. An eligible expense is incurred on the date the services are received or on the date supplies are purchased or rented. If an anticipated expense is not specifically described as an eligible expense in your policy, it is your responsibility to contact us **before** you incur the expense to confirm whether an expense is eligible. We may deny a claim if you have not confirmed with us whether the expense is eligible.

We may require itemized bills, attending physician statements, commercial laboratory receipts, reports, records, x-rays, study models or other information we consider necessary to assess a claim. You must pay any additional cost associated with providing this information.

After your policy ends:
We must receive your claim within three months of the date your policy ended. We will not pay for any claims received by us more than three months after the date your policy ended, regardless of when the eligible expense was incurred.

Payment of claims

We will pay claims when we receive proof you have incurred an eligible expense. We determine the amount to be paid by:

- applying the reimbursement percentage, and
- then applying the maximums.

How we calculate the amount we'll pay
We confirm all expenses you submit are eligible expenses. We determine if there are any limitations which are described in the applicable provisions. If any of the expenses aren't eligible, we subtract that expense from the total amount you are claiming.

For each eligible expense, we compare:
- the amount you are claiming,
- the customary charge for the expense, and
- the maximum amount you can claim as described on the *Plan summary* page.

The amount we pay is based on the lowest of these three amounts.

Time limit for recovery of insurance money

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or the provincial or territorial legislation that applies to this policy.

Recovering payments from a third party (Subrogation)

If we've made a payment under this policy as a result of an illness, injury or accident that a third party is or may be responsible for, we'll assert our right of reimbursement, where permitted by law.

Your obligation to reimburse us will not exceed the amount of the benefit we've paid. Our right of reimbursement will apply to any full or partial payments you are entitled to or may receive.

We won't be bound or affected by any compromised settlement between you and the third party unless you have our prior written consent. When a claim is settled and a lump sum payment is made, it is your responsibility to prove that no amount of that lump sum was intended as payment for the eligible expenses we have paid under this policy.

If you do not assert your rights against the third party, you agree, where permitted by law, to assign all of your legal rights against the third party to us.

General exclusions

We will not pay for expenses:

- incurred, directly or indirectly caused by or associated with civil disorder or war, whether declared or not; or service in the naval, military or air force of any country, combination of countries or international organization at war, whether war is declared or not,
- that we are not legally allowed to pay,
- for services or items that we consider cosmetic,
- for services or items that we consider experimental,
- for delivery, transportation and administration charges,
- for services and products that are self-prescribed or are rendered or prescribed by a person who is ordinarily a resident in the insured person's home or who is related to the insured person by blood or marriage,
- 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,
- for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- 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,
- for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada), and
- for elective (non-emergency) medical treatment or surgery which is received or performed out of province where they live.

We will also not pay for intentionally self-inflicted injuries, while sane or insane.

Drug provision

Covered drugs and drug supplies

- drugs that must be prescribed and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription,
- life-sustaining drugs that may not require a prescription and are identified in the Therapeutic Guide section of the current Compendium of Pharmaceuticals and Specialties under the following headings:
    - anti-anginal agents
    - antiparkinsonism agents
    - bronchodilators
    - antihyperlipidemic agents
    - hyperthyroidism therapy
    - parasympathomimetic agents
    - tuberculosis therapy
    - anticholinergic preparations
    - anti-arrhythmic agents
    - glaucoma therapy
    - insulin preparations
    - oral fibrinolytic agents
    - potassium replacement therapy
    - topical enzymatic debriding agents
- injectible drugs,
- compounded prescriptions where one of the ingredients is an eligible covered drug,
- needles, syringes, and chemical diagnostic aids for the treatment of diabetes, and
- aids to help a person quit smoking that require a prescription and are limited to a maximum of $250 lifetime.

The maximum amount we will pay for any single purchase is limited to the cost of any eligible drugs or drug supplies that can reasonably be used in a three month period.

Eligibility criteria for drugs and drug supplies

We will cover eligible expenses up to the limit specified on the *Plan summary* page.
For a drug or a related supply to be an eligible expense, it must meet all of the following criteria. It must be:

- medically necessary for the treatment of injury or illness,
- reasonable and customary charges for the treatment of injury or illness,
- prescribed by a doctor, dentist, or other authorized medical professional, as determined by the province where the professional is licensed, registered and is prescribing, and
- dispensed by a registered pharmacist or doctor.

Generic substitution

The maximum amount we pay for an eligible brand name drug is limited to the lowest priced item in the appropriate generic category. If the physician or dentist has stated on the prescription form that there should not be any substitution then we cover eligible expenses up to the limit specified on the *Plan summary* page.

Exclusions

We will not pay for, even when prescribed:

- drugs used for the treatment of infertility,
- drugs for the treatment of erectile dysfunction,
- drugs used for the treatment of obesity,
- dietary supplements, vitamins and infant foods,
- contraceptives,
- the cost of giving injections, serums and vaccines,
- over-the-counter products designed to help a person quit smoking, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Extended health provision

Eligible expenses
- reasonable and customary charges for the services or supplies listed below,
- determined by us to be medically necessary for the treatment of illness or injury, and
- prescribed by a physician unless otherwise indicated.

All maximum amounts set out in this provision apply individually to each insured person.

We will pay for the services of the practitioners listed below. The service must be performed within the practitioner's area of expertise and require the skills and qualifications of that practitioner.

Prescription required for the services of a:
- acupuncturist,
- physiotherapist,
- psychologist,
- registered massage therapist, or
- speech language pathologist.

Prescription not required for the services of a:
- chiropractor, including one x-ray examination in a calendar year,
- naturopath,
- osteopath, including one x-ray examination in a calendar year, or
- podiatrist or chiropodist, including one x-ray examination per calendar year.

The amount we pay is limited to a maximum of $25 per visit and calendar year maximum of $250 for each practitioner.

For the services of a chiropractor, podiatrist and chiropodist, we will reimburse expenses before you exceed the annual maximums under the provincial health care plan.

We will pay for the services of a dental surgeon required to treat a fractured jaw or accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means. These services include a dental prosthesis. We will not pay for any services required to treat a fracture or injury because of a condition that existed before the fracture or injury. The amount we pay is limited to $2,000 per fracture or injury. Services must be performed within 12 months of the fracture or injury. We do not require a physician's prescription for these services to be eligible.

We will pay for licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the insured person prevents the use of another means of transportation. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the insured person prevents the use of another means of transportation. If the insured person requires the services of a registered nurse during the flight, we will pay for their services and their return air fare. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for hearing aids and repairs to them, excluding batteries, limited to $400 during a five year period. The five year period begins from the date the first expense is incurred. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for the following provincially funded services and equipment, limited to a combined calendar year maximum of $2,500 and a combined lifetime maximum of $20,000.

We will pay when we *receive proof* that the insured person has applied for the applicable government funding for:
- artificial limbs or other prosthetic appliances,
- braces, provided they are not solely for athletic use,
- oxygen,

- services of a nurse provided in the insured person's home. The insured person's treatment must require the level of expertise of a nurse,
- walkers, if we have approved either its purchase or rental,
- wheel chair limited to $1,000 lifetime, if we have approved either its purchase or rental, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

We will pay *without proof* that the insured person has applied for the applicable government funding for:
- blood glucose monitors, limited to $150 during a five year period,
- diagnostic laboratory and x-ray examinations,
- custom made orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required to correct a deformity of the bones and muscles and not solely for athletic use. They must be prescribed by a physician, podiatrist, chiropodist or chiropractor. The amount we pay is limited to $150 in a calendar year,
- durable equipment (but not walkers or wheelchairs) if we have approved either its purchase or rental. An example of durable equipment in this provision is a hospital bed or a traction kit,
- plaster of paris or fibreglass casts,
- splints and crutches,
- wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a maximum of $100 in a calendar year, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment, that meets the insured person's basic medical needs.

For Quebec residents only, we will pay for magnetic resonance imaging (MRI), computerized axial tomography (CAT) and computerized tomography (CT) scans, and ultrasounds to a combined maximum of $750 in a calendar year.

Exclusions

We will not pay for:
- the services of a homemaker or home service worker,
- items purchased solely for athletic use,
- dental expenses, except those specifically provided under eligible expenses for treatment of accidental injuries to natural teeth,
- utilization fees which are imposed by the provincial health care plan for the use of a service, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Preventive dental provision

Eligible expenses
We will cover eligible expenses up to the limit specified on the *Plan summary* page.
If an anticipated expense is not specifically described as an eligible expense in your policy, it is your responsibility to contact us before you incur the expense to confirm whether an expense is eligible.We may deny a claim if you have not confirmed with us whether the expense is eligible.

Description of coverage
Dental care coverage pays for eligible expenses that an insured person incurs for dental procedures performed by a licensed dentist, denturist, dental hygienist or anaesthetist.

For each dental procedure, only reasonable expenses will be covered if they are:
- up to the usual charge for the most economical alternate procedure, service or treatment,
- consistent with accepted dental practice, and
- appropriate for the insured person's condition.

We have the right to obtain an independent dental opinion at your expense before a procedure is performed to verify if the treatment is appropriate. In no case will the eligible expense be more than the fee stated in the dental fee guide for the province in which the insured person incurs the expense.

How claims are paid
We will pay for eligible expenses taking into account all limitations described in this provision.

An expense is incurred on the date the dentist performs a single appointment procedure. For procedures which take more than one appointment, an insured person incurs an expense once the entire procedure is complete.

If an insured person receives any temporary dental service, we consider it part of the final dental procedure used to correct the problem and not a separate procedure. The fee for the final dental procedure will be used to determine the reasonable and customary charge for the temporary dental service.

To determine eligibility, we may require the insured person's dentist to provide us with a statement of the treatment received, pre-treatment x-rays and any additional information we consider necessary.

What is covered
The following dental procedures are eligible expenses.

Preventive dental procedures
- oral examinations:
  - one complete examination every five years,
  - one recall examination every nine months,
  - emergency or specific examinations,
- x-rays:
  - one complete series of x-rays or one panorex every five years,
  - one set of bitewing x-rays every 18 months,
  - x-rays to diagnose a symptom or examine progress of a particular course of treatment,
- consultation with another dentist, if required by the insured person's dentist,
- polishing (cleaning of teeth) and topical fluoride treatment once every nine months,
- interproximal discing (limited to one for each insured person under 12 years of age),
- recontouring of teeth for functional reasons,
- caries control,
- trauma control,
- emergency services,
- palliative services,
- diagnostic tests and laboratory examinations,
- space maintainers for missing primary teeth (for insured persons under 12 years of age),
- pit and fissure sealants (for insured persons under 19 years of age),

- fillings – amalgam, composite, acrylic, or the equivalent of these fillings. When a bonded amalgam filling is placed on any tooth, we determine eligible expenses on the basis of the cost of an equivalent non-bonded amalgam,
- uncomplicated removal of teeth (procedure does not require surgical flap or sectioning of the tooth),
- prefabricated metal or plastic restorations and repairs to prefabricated metal or plastic restorations, other than in conjunction with the placement of permanent crowns, and
- scaling and root planing (not to exceed eight time units per year).

Limitations

The amount payable for an eligible expense is limited to the least expensive treatment that produces a professionally adequate result. If the insured person and dentist choose a more expensive course of treatment, payment is limited to the lower cost of the alternative treatment that we determine.

Each year the Canadian Dental Association (CDA) publishes a list of services and procedure codes. If there is a change in the CDA procedure codes, or if we cannot determine that the expenses incurred are eligible expenses, payment may be based on the charges for similar services which are eligible expenses.

Exclusions

We will not pay for:

- replacement of periodontal appliances and space maintainers which have been lost, stolen or misplaced,
- full mouth reconstructions for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- expenses incurred for the treatment of malocclusion or for orthodontic treatment,
- services rendered in conjunction with surgical services payable under a government plan,
- dental services required due to congenital malformation,
- charges for appointments that an insured person does not keep,
- charges for completing claim forms, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Appendix – Statutory conditions

The Policy

The application, the Policy particulars page, this policy and any amendment to the policy agreed upon in writing after this policy is issued, constitute the entire policy, and no agent has authority to change the policy or waive any of its provisions.

Waiver

We are deemed not to have waived any condition of this policy, either in whole or in part, unless our waiver is clearly expressed in writing signed by our authorized signing officers.

Copy of application

We will on your request, give you a copy of the application for this policy.

Material facts

No statement made by an insured person at the time of application for this policy can be used in defense of a claim under or to avoid this policy unless it is in the application or any other written statements or answers given as evidence of insurability.

Termination by us

We may terminate this policy at any time by giving written notice of termination to you and by refunding concurrently with the notice, the amount of premium paid in excess of the proportional premium for the expired time. The written notice may be delivered to you or sent by registered mail to the last address we have recorded for you in our records.

Termination of insurance
We may terminate your policy by giving you 15 days written notice by registered mail.

Termination for non-payment
If the initial premium has not been fully paid when due, we may terminate your policy by giving you 15 days written notice by registered mail.

The 15 days notice of termination by registered mail starts on the day the registered letter or notification of it is delivered to your postal address.

Notice and proof of claim

You must send us written notice of all claims not later than the time period set out in your policy for making a claim by sending claims either by regular mail to us or electronically, where available.

You must give us any proof we consider is reasonably necessary for a claim.

Failure to give notice or proof

Failure to give notice of claim or provide proof of a claim within the time limit set out in this statutory condition does not invalidate the claim if you give notice or proof as soon as is reasonably possible and in no event later than12 months from the date that an eligible expense is incurred.

When money is payable

All money payable under this policy shall be paid by us within 60 days after we receive satisfactory proof of claim.

Insurer to furnish forms for proof of claim

We shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident giving rise to the claim.

Randstad Affiliation Plan Extended Health Care and Dental Insurance Policy

Basic plan

Quebec

Sun Life Financial

Sun Life Assurance Company of Canada agrees with you, the policy owner, to pay the benefits of this policy according to its terms and conditions.

In this document, you and your mean the owner of this policy.
We, us, our, and the company mean Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Signed at Toronto, Ontario

Dean Connor
President and Chief Executive Officer
Sun Life Assurance Company of Canada

Dana Easthope
Vice-President, Associate General Counsel and Corporate Secretary
Sun Life Assurance Company of Canada

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7th Floor
Toronto, ON M5V 3C5
1 800 669 7921

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Note:
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Drug
The amount we pay for the dispensing fee reimbursement is 100 per cent but is limited to a maximum of $5 per prescription.

If you have prescription drug insurance through the Régie de l'assurance maladie du Québec (RAMQ), this means that your prescription drug claims must first be submitted to RAMQ. Any remaining, unpaid portion that is eligible under this policy can then be submitted to us for reimbursement. The coinsurance and deductible that an insured person must pay under their plan with the RAMQ are eligible under this policy.

If you have group drug coverage and are not covered by RAMQ prescription drug insurance, your prescription drug claims must first be submitted to your group policy. Any remaining, unpaid portion that is eligible under this policy can then be submitted to us for reimbursement. If your group drug coverage is with us please contact us to co-ordinate drug benefits between your group policy and this policy. If your group drug coverage ends, you must then obtain RAMQ prescription drug insurance to remain eligible under this policy.

Waiting period
Dental
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General provisions

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Lifetime maximum	the maximum amount we will pay for each insured person, while this policy is in effect.
Naturopath	a member of the Canadian Naturopathic Association or any provincial association affiliated with it.
Nurse	an out-of-hospital private duty nurse, when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse who is licensed, certified or registered in the province where the insured person lives and who does not normally live with the insured person and includes a registered nurse (RN), registered nursing assistant (RNA), certified nursing assistant (CNA), licensed practical nurse (LPN) or a registered practical nurse (RPN).

Osteopath	a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association.
Paradental practitioner	a person licensed by the appropriate provincial authority to work as a practitioner fitting dentures for, and supplying dentures directly to, the public.
Physician	a doctor of medicine (M.D.) licensed to practice medicine.
Physiotherapist	a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it.
Policy anniversary	the month and day every year that is the same date as your policy date.
Psychologist	a certified psychologist who is listed on the appropriate provincial registry in the province in which the service is rendered.
Reasonable and customary charges	for *dental professional fees*, fees which are usually charged to a person without insurance and which are not greater than the fees in the dental fee guide. for *health expenses and dental laboratory charges*, mean amounts which are usually charged to a person without insurance and are not greater than the general level of charges in the area where the expenses are incurred.
Registered massage therapist	a person licensed by the appropriate provincial licensing body to practice massage therapy, or in the absence of a provincial licensing body, a person whose qualifications meet those required by a licensing body to practice massage therapy.
Registered pharmacist	a person who is licensed to practice pharmacology and whose name is listed on the pharmacists' registry of the licensing body for the jurisdiction in which such person is practising.
Speech language pathologist	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.

The Policy

This policy, which includes the application, the *Policy particulars* page and any amendment agreed to in writing, may not be changed or any provisions waived unless agreed to in writing by our officers authorized to sign policies.

The currency of this policy is Canadian.

If you or another insured person fail to tell us every fact material to the insurance, or misrepresent those facts, we may void the insurance.

Statements made on the application or on an evidence of insurability form, which are fraudulent, or a misstatement of age, may be contested at any time. Other statements are incontestable two years after the statements are made.

Premiums

The premium is determined according to the age of each insured person and the province where they live. If a change in age puts the insured person into another rate category, premiums are adjusted at the next policy anniversary. If an insured person changes the province where they live, premiums are adjusted according to the rates of the new province of residence and are effective on the date of the change.

We have the right to change your premium. We will give you 30 days written notice before the change is made.

Grace period

The grace period is 31 days for the payment of premiums and is allowed for each premium except the first. During the grace period, insurance remains in force and premiums continue to be payable by you.

We will terminate the policy when payment has not been made before the end of the grace period. We will send you written notice of termination. Any claims for expenses incurred after the policy has terminated are not eligible for payment.

Eligibility requirements

To be eligible, and continue to be eligible for coverage under this policy, a person must be:

- a resident of Canada,
- covered under provincial health insurance,
    - Quebec residents must also have and continue to have health and drug coverage through a group benefit plan or through Régie de l'assurance maladie du Québec (RAMQ). A person not covered under a group benefit plan or through RAMQ, is not eligible for coverage under this policy.
- related to you in one of the following ways:
    - legally married to you or in a civil union,
    - living with you in a conjugal relationship and represented as your spouse or partner, or
    - a child born to you, adopted by you, or a step child, who is unmarried and entirely dependent on you for maintenance and support and who is also:
        i) under 21 years of age, or
        ii) under 25 years of age and attending a college or university full time, or
        iii) physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on you while eligible under i) or ii).

It is your responsibility to tell us when an insured person no longer meets the eligibility requirements.

Changes

Changing plan type
You may apply at any time to change your existing plan type (basic, standard or enhanced) to any other plan type we offer at the time you apply for the change. You must apply in writing. We will require new evidence of insurability from all insured persons. If your application is approved, the change to your plan type takes effect on the date we determine.

Adding an insured person
Child
You may apply in writing to add a child as an insured person under this policy. This change takes effect on the later of the date we approve your request or the beginning of the next monthly coverage period for your policy.

We will add your newborn children without evidence if you ask us to add them within 30 days of their birth.

For any child you ask us to add, we may require you to prove the child's relationship to you. We will also tell you if you need to provide evidence of insurability for the child you want to add who is age 31 days or older.

You may apply to add any child who is unmarried and entirely dependent on you for maintenance and support and is either born to you, adopted by you, or is a stepchild and is:

i) under 21 years of age, or
ii) under 25 and attending college or university full time, or
iii) physically or mentally incapable of self-support and became incapable of self-support while entirely dependent on you for maintenance and support while eligible under i) or ii).

Other eligible persons
You may ask us to add a person to the list of insured persons. You must make this request in writing. The person must meet our eligibility requirements and give evidence of insurability satisfactory to us. This change takes effect on the later of the date we approve your request or the beginning of the next monthly coverage period for your policy.

Removing an insured person
If you ask us in writing, we will remove an insured person from this policy. This change takes effect at the beginning of the next monthly coverage period for your policy.

Your right to cancel this policy

You may cancel this policy at any time by sending a written request to the address shown at the beginning of the policy. We must receive a minimum of ten days advance written notice of termination.

Claims

We must receive your claim within 12 months of the date the eligible expense is incurred. An eligible expense is incurred on the date the services are received or on the date supplies are purchased or rented. If an anticipated expense is not specifically described as an eligible expense in your policy, it is your responsibility to contact us **before** you incur the expense to confirm whether an expense is eligible. We may deny a claim if you have not confirmed with us whether the expense is eligible.

We may require itemized bills, attending physician statements, commercial laboratory receipts, reports, records, x-rays, study models or other information we consider necessary to assess a claim. You must pay any additional cost associated with providing this information.

After your policy ends:
We must receive your claim within three months of the date your policy ended. We will not pay for any claims received by us more than three months after the date your policy ended, regardless of when the eligible expense was incurred.

Payment of claims

We will pay claims when we receive proof you have incurred an eligible expense. We determine the amount to be paid by:

- applying the reimbursement percentage, and
- then applying the maximums.

How we calculate the amount we'll pay
We confirm all expenses you submit are eligible expenses. We determine if there are any limitations which are described in the applicable provisions. If any of the expenses aren't eligible, we subtract that expense from the total amount you are claiming.

For each eligible expense, we compare:
- the amount you are claiming,
- the customary charge for the expense, and
- the maximum amount you can claim as described on the *Plan summary* page.

The amount we pay is based on the lowest of these three amounts.

Recovering payments from a third party (Subrogation)

If we've made a payment under this policy as a result of an illness, injury or accident that a third party is or may be responsible for, we'll assert our right of reimbursement, where permitted by law.

Your obligation to reimburse us will not exceed the amount of the benefit we've paid. Our right of reimbursement will apply to any full or partial payments you are entitled to or may receive.

We won't be bound or affected by any compromised settlement between you and the third party unless you have our prior written consent. When a claim is settled and a lump sum payment is made, it is your responsibility to prove that no amount of that lump sum was intended as payment for the eligible expenses we have paid under this policy.

If you do not assert your rights against the third party, you agree, where permitted by law, to assign all of your legal rights against the third party to us.

General exclusions

We will not pay for expenses:

- incurred, directly or indirectly caused by or associated with civil disorder or war, whether declared or not; or service in the naval, military or air force of any country, combination of countries or international organization at war, whether war is declared or not,
- that we are not legally allowed to pay,
- for services or items that we consider cosmetic,
- for services or items that we consider experimental,
- for delivery, transportation and administration charges,
- for services and products that are self-prescribed or are rendered or prescribed by a person who is ordinarily a resident in the insured person's home or who is related to the insured person by blood or marriage,
- 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,
- for services or supplies that are not approved by Health Canada or other government regulatory body for the general public,
- 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,
- for services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada), and
- for elective (non-emergency) medical treatment or surgery which is received or performed out of province where they live.

We will also not pay for intentionally self-inflicted injuries, while sane or insane.

Drug provision

Covered drugs and drug supplies

- drugs that must be prescribed and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription,
- life-sustaining drugs that may not require a prescription and are identified in the Therapeutic Guide section of the current Compendium of Pharmaceuticals and Specialties under the following headings:
    - anti-anginal agents
    - antiparkinsonism agents
    - bronchodilators
    - antihyperlipidemic agents
    - hyperthyroidism therapy
    - parasympathomimetic agents
    - tuberculosis therapy
    - anticholinergic preparations
    - anti-arrhythmic agents
    - glaucoma therapy
    - insulin preparations
    - oral fibrinolytic agents
    - potassium replacement therapy
    - topical enzymatic debriding agents
- injectible drugs,
- compounded prescriptions where one of the ingredients is an eligible covered drug,
- needles, syringes, and chemical diagnostic aids for the treatment of diabetes, and
- aids to help a person quit smoking that require a prescription and are limited to a maximum of $250 lifetime.

The maximum amount we will pay for any single purchase is limited to the cost of any eligible drugs or drug supplies that can reasonably be used in a three month period.

Eligibility criteria for drugs and drug supplies

We will cover eligible expenses up to the limit specified on the *Plan summary* page.

For a drug or a related supply to be an eligible expense, it must meet all of the following criteria. It must be:

- medically necessary for the treatment of injury or illness,
- reasonable and customary charges for the treatment of injury or illness,
- prescribed by a doctor, dentist, or other authorized medical professional, as determined by the province where the professional is licensed, registered and is prescribing, and
- dispensed by a registered pharmacist or doctor.

Generic substitution

The maximum amount we pay for an eligible brand name drug is limited to the lowest priced item in the appropriate generic category. If the physician or dentist has stated on the prescription form that there should not be any substitution then we cover eligible expenses up to the limit specified on the *Plan summary* page.

Exclusions

We will not pay for, even when prescribed:

- drugs used for the treatment of infertility,
- drugs for the treatment of erectile dysfunction,
- drugs used for the treatment of obesity,
- dietary supplements, vitamins and infant foods,
- contraceptives,
- the cost of giving injections, serums and vaccines,
- over-the-counter products designed to help a person quit smoking, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Extended health provision

Eligible expenses

- reasonable and customary charges for the services or supplies listed below,
- determined by us to be medically necessary for the treatment of illness or injury, and
- prescribed by a physician unless otherwise indicated.

All maximum amounts set out in this provision apply individually to each insured person.

We will pay for the services of the practitioners listed below. The service must be performed within the practitioner's area of expertise and require the skills and qualifications of that practitioner.

Prescription required for the services of a:

- acupuncturist,
- physiotherapist,
- psychologist,
- registered massage therapist, or
- speech language pathologist.

Prescription not required for the services of a:

- chiropractor, including one x-ray examination in a calendar year,
- naturopath,
- osteopath, including one x-ray examination in a calendar year, or
- podiatrist or chiropodist, including one x-ray examination per calendar year.

The amount we pay is limited to a maximum of $25 per visit and calendar year maximum of $250 for each practitioner.

For the services of a chiropractor, podiatrist and chiropodist, we will reimburse expenses before you exceed the annual maximums under the provincial health care plan.

We will pay for the services of a dental surgeon required to treat a fractured jaw or accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental means. These services include a dental prosthesis. We will not pay for any services required to treat a fracture or injury because of a condition that existed before the fracture or injury. The amount we pay is limited to $2,000 per fracture or injury. Services must be performed within 12 months of the fracture or injury. We do not require a physician's prescription for these services to be eligible.

We will pay for licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the insured person prevents the use of another means of transportation. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the insured person prevents the use of another means of transportation. If the insured person requires the services of a registered nurse during the flight, we will pay for their services and their return air fare. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for hearing aids and repairs to them, excluding batteries, limited to $400 during a five year period. The five year period begins from the date the first expense is incurred. We will pay when we receive proof that the insured person has applied for the applicable government funding for this service.

We will pay for the following provincially funded services and equipment, limited to a combined calendar year maximum of $2,500 and a combined lifetime maximum of $20,000.

We will pay when we *receive proof* that the insured person has applied for the applicable government funding for:

- artificial limbs or other prosthetic appliances,
- braces, provided they are not solely for athletic use,
- oxygen,

- services of a nurse provided in the insured person's home. The insured person's treatment must require the level of expertise of a nurse,
- walkers, if we have approved either its purchase or rental,
- wheel chair limited to $1,000 lifetime, if we have approved either its purchase or rental, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

We will pay *without proof* that the insured person has applied for the applicable government funding for:
- blood glucose monitors, limited to $150 during a five year period,
- diagnostic laboratory and x-ray examinations,
- custom made orthopaedic shoes, orthopaedic modifications to shoes, and orthotics, when they are required to correct a deformity of the bones and muscles and not solely for athletic use. They must be prescribed by a physician, podiatrist, chiropodist or chiropractor. The amount we pay is limited to $150 in a calendar year,
- durable equipment (but not walkers or wheelchairs) if we have approved either its purchase or rental. An example of durable equipment in this provision is a hospital bed or a traction kit,
- plaster of paris or fibreglass casts,
- splints and crutches,
- wigs and hairpieces required as a result of alopecia, chemotherapy, or radiation therapy, limited to a maximum of $100 in a calendar year, and
- repairs to durable medical equipment we cover under this policy will be reimbursed up to the percentage indicated on the *Plan summary* page.

If alternate durable equipment is available, eligible expenses are limited to the cost of the least expensive equipment, that meets the insured person's basic medical needs.

For Quebec residents only, we will pay for magnetic resonance imaging (MRI), computerized axial tomography (CAT) and computerized tomography (CT) scans, and ultrasounds to a combined maximum of $750 in a calendar year.

Exclusions

We will not pay for:
- the services of a homemaker or home service worker,
- items purchased solely for athletic use,
- dental expenses, except those specifically provided under eligible expenses for treatment of accidental injuries to natural teeth,
- utilization fees which are imposed by the provincial health care plan for the use of a service, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Preventive dental provision

Eligible expenses
We will cover eligible expenses up to the limit specified on the *Plan summary* page.
If an anticipated expense is not specifically described as an eligible expense in your policy, it is your responsibility to contact us before you incur the expense to confirm whether an expense is eligible. We may deny a claim if you have not confirmed with us whether the expense is eligible.

Description of coverage
Dental care coverage pays for eligible expenses that an insured person incurs for dental procedures performed by a licensed dentist, denturist, dental hygienist or anaesthetist.

For each dental procedure, only reasonable expenses will be covered if they are:
- up to the usual charge for the most economical alternate procedure, service or treatment,
- consistent with accepted dental practice, and
- appropriate for the insured person's condition.

We have the right to obtain an independent dental opinion at your expense before a procedure is performed to verify if the treatment is appropriate. In no case will the eligible expense be more than the fee stated in the dental fee guide for the province in which the insured person incurs the expense.

How claims are paid
We will pay for eligible expenses taking into account all limitations described in this provision.

An expense is incurred on the date the dentist performs a single appointment procedure. For procedures which take more than one appointment, an insured person incurs an expense once the entire procedure is complete.

If an insured person receives any temporary dental service, we consider it part of the final dental procedure used to correct the problem and not a separate procedure. The fee for the final dental procedure will be used to determine the reasonable and customary charge for the temporary dental service.

To determine eligibility, we may require the insured person's dentist to provide us with a statement of the treatment received, pre-treatment x-rays and any additional information we consider necessary.

What is covered
The following dental procedures are eligible expenses.

Preventive dental procedures
- oral examinations:
  - one complete examination every five years,
  - one recall examination every nine months,
  - emergency or specific examinations,
- x-rays:
  - one complete series of x-rays or one panorex every five years,
  - one set of bitewing x-rays every 18 months,
  - x-rays to diagnose a symptom or examine progress of a particular course of treatment,
- consultation with another dentist, if required by the insured person's dentist,
- polishing (cleaning of teeth) and topical fluoride treatment once every nine months,
- interproximal discing (limited to one for each insured person under 12 years of age),
- recontouring of teeth for functional reasons,
- caries control,
- trauma control,
- emergency services,
- palliative services,
- diagnostic tests and laboratory examinations,
- space maintainers for missing primary teeth (for insured persons under 12 years of age),
- pit and fissure sealants (for insured persons under 19 years of age),

- fillings – amalgam, composite, acrylic, or the equivalent of these fillings. When a bonded amalgam filling is placed on any tooth, we determine eligible expenses on the basis of the cost of an equivalent non-bonded amalgam,
- uncomplicated removal of teeth (procedure does not require surgical flap or sectioning of the tooth),
- prefabricated metal or plastic restorations and repairs to prefabricated metal or plastic restorations, other than in conjunction with the placement of permanent crowns, and
- scaling and root planing (not to exceed eight time units per year).

Limitations
The amount payable for an eligible expense is limited to the least expensive treatment that produces a professionally adequate result. If the insured person and dentist choose a more expensive course of treatment, payment is limited to the lower cost of the alternative treatment that we determine.

Each year the Canadian Dental Association (CDA) publishes a list of services and procedure codes. If there is a change in the CDA procedure codes, or if we cannot determine that the expenses incurred are eligible expenses, payment may be based on the charges for similar services which are eligible expenses.

Exclusions
We will not pay for:
- replacement of periodontal appliances and space maintainers which have been lost, stolen or misplaced,
- full mouth reconstructions for vertical dimension correction or for correction of temporomandibular joint dysfunction,
- expenses incurred for the treatment of malocclusion or for orthodontic treatment,
- services rendered in conjunction with surgical services payable under a government plan,
- dental services required due to congenital malformation,
- charges for appointments that an insured person does not keep,
- charges for completing claim forms, and
- expenses incurred under any of the conditions specified in the *General exclusions* section of the *General provisions* pages.

Appendix – Statutory conditions

The Policy

The application, the Policy particulars page, this policy and any amendment to the policy agreed upon in writing after this policy is issued, constitute the entire policy, and no agent has authority to change the policy or waive any of its provisions.

Waiver

We are deemed not to have waived any condition of this policy, either in whole or in part, unless our waiver is clearly expressed in writing signed by our authorized signing officers.

Copy of application

We will on your request, give you a copy of the application for this policy.

Material facts

No statement made by an insured person at the time of application for this policy can be used in defense of a claim under or to avoid this policy unless it is in the application or any other written statements or answers given as evidence of insurability.

Termination by us

We may terminate this policy at any time by giving written notice of termination to you and by refunding concurrently with the notice, the amount of premium paid in excess of the proportional premium for the expired time. The written notice may be delivered to you or sent by registered mail to the last address we have recorded for you in our records. Where notice is delivered to you, five calendar days notice of termination will be given. Where notice is sent by registered mail, ten calendar days notice will be given and the ten days begin on the day following the date of mailing.

Notice and proof of claim

You must send us written notice of all claims not later than the time period set out in your policy for making a claim by sending claims either by regular mail to us or electronically, where available.

You must give us any proof we consider is reasonably necessary for a claim.

Failure to give notice or proof

Failure to give notice of claim or provide proof of a claim within the time limit set out in this statutory condition does not invalidate the claim if you give notice or proof as soon as is reasonably possible and in no event later than12 months from the date that an eligible expense is incurred.

When money is payable

All money payable under this policy shall be paid by us within 60 days after we receive satisfactory proof of claim.

Insurer to furnish forms for proof of claim

We shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident giving rise to the claim.