NCBAA
Trust Fund - Health Care Plan

Eligible represented retirees of NAV CANADA who retire on or after January 1, 2010

Contract Number 150052

Effective January 1, 2010
Amended March 1, 2016

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To: All participants of the NCBAA Trust Fund - Health Care Plan - Policy #150052

We are pleased to provide you with this e-booklet that outlines the group benefits available to you and your eligible dependents through the NCBAA Trust Fund - Health Care Plan.

The e-booklet provides an outline of the coverage and benefits as well as various other aspects of the Plan such as administrative and claims procedures, privileges, etc.

These arrangements have been made on your behalf and we trust that you will agree that the NCBAA Health Care Plan is proof of our continued interest in the security and well-being of you and your family in retirement.

The administration of the Plan will be handled by Coughlin & Associates Ltd. Sun Life Financial only acts as the underwriter and claims adjudicator. Only claims related questions are to be directed to Sun Life Financial, all other issues are to be directed to Coughlin & Associates Ltd.

We encourage you to read the e-booklet carefully and familiarize yourself with the benefits.

Fraternally yours,

The Trustees of the NCBAA Trust Fund

Ruth Beilman
Scott Chamberlain
David Gainforth

Personal information protection

The administrator of your group benefit plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

Plan administrator: Coughlin & Associates Ltd.

Street address:	Mailing address:
466 Tremblay Road	Box 3517, Station C
OTTAWA, ON K1G 3R1	OTTAWA, ON K1Y 4H5

E-mail:	webmaster @ coughlin.ca
Telephone:	613-231-2266
Toll free:	888-613-1234
Fax:	613-231-2345

General Information

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.
- you retire on or after January 1, 2010.
- you were covered as a union employee under the NAV CANADA group plan on the day preceding your retirement.
- when you retire, you do not opt for a transfer of the commuted value of your pension entitlement and you are eligible for an immediate pension benefit.
- you have at least 15 years of pension eligibility service or be in receipt of a monthly pension from NAV CANADA.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada. To qualify for coverage, your dependent must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

Your spouse by marriage or under any other formal union recognized by law, or your partner who is publicly represented as your spouse, is an eligible dependent. You can only cover one spouse at a time.

Your children and your spouse's children (including foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, we will continue coverage as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

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

Proof of eligibility

Supporting documents as defined below must be provided to and approved by the contract holder before coverage is in effect.

Spouse – Both the birth certificate of spouse and marriage certificate.

Common law spouse – Both the birth certificate of common law partner and statutory declaration.

Child – Birth certificate.

Foster child – Birth certificate and legal guardianship documentation.

Adopted child – Birth certificate (and legal guardianship documentation if not on birth certificate).

Step-child – Birth certificate (will only be eligible if spouse/common-law partner approved).

Child over age 21 – Proof of enrolment as full-time student (to be provided annually) OR approval of disability status from Sun Life (to be provided once).

How to enrol

Prior to your retirement date, if you are interested in having Health Care benefits during retirement, you will have to complete the NCBAA Trust Fund - Health Care Plan application.

The application is available on the NCBAA Trust Fund Plan administrator's website at: www.coughlin.ca/ncbaa-aannc. Simply click on the forms button on the blue menu bar. Then click on Health Care Plan application. Simply complete the application and return it either by mail, fax or e-mail to the Plan administrator. When returning the completed and signed application, please identify the NCBAA Trust Fund in the subject line of your letter, fax or e-mail.

Plan administrator: Coughlin & Associates Ltd.

Street address:	Mailing address:
466 Tremblay Road	Box 3517, Station C
OTTAWA, ON K1G 3R1	OTTAWA, ON K1Y 4H5

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Fax:	613-231-2345

When coverage begins

Your coverage will begin on the date you become eligible for coverage.

Your coverage will begin on the first of the month following the second month after your date of retirement.

For example, if your retirement date is any date in the month of January, your coverage will begin on March 1st.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

Once you have dependent coverage, any subsequent dependents will be covered automatically.

Updating your records

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

- change of dependents.
- change of name.

When coverage ends

Your coverage will end on the date the benefit provision under which you are covered terminates.

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

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

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

- the date the person would no longer be considered your dependent if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.
- death of the dependent.

Payment of premiums

By making application for the Health Care coverage, you authorize NAV Canada to deduct monthly from your pension the amount, inclusive of applicable tax(es), for the coverage and to have those premiums and applicable tax(es) remitted to the NCBAA on your behalf.

If your pension is not sufficient to cover the required premium, you will be responsible to pay the Plan administrator, Coughlin & Associates Ltd., directly with monthly post-dated cheques or automatic bank withdrawal.

The premiums will be shared with the NCBAA Trust Fund. It is understood, as a participant of the Plan, that the NCBAA Trust Fund is responsible for the provision of retiree Health Care benefits and as such these benefits are subject to ongoing review and revision of all facets of benefits, cost sharing arrangements and premiums. The NCBAA reserves the rights to alter or discontinue any and all benefits subject to the provision of the terms of the NCBAA Trust Fund Trust Agreement.

Survivor benefits

If the deceased was an eligible represented employee of NAV Canada who retired on or after January 1, 2010 and subsequently passed away, the surviving spouse and eligible children receiving a NAV Canada pension benefit and living in Canada with provincial Health Care coverage will be eligible to continue coverage as long as premiums are paid up or coverage eligibility ends.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact the Plan administrator or access the website at www.coughlin.ca/ncbaa-aannc to get the proper form to make a claim. There are time limits for making claims. These limits are discussed in the appropriate sections of this group benefits e-booklet. All claims must be made in writing on forms approved by Sun Life.

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

How to claim

Hospital room expenses

If you, your spouse, or any of your children are hospitalized, give the admitting clerk your contract number, 150052, and insurance company name, Sun Life Financial.

Generally, hospitals bill the Plan directly. If your hospital does not, send a completed claim form with the hospital's invoice to Sun Life. They will either pay the hospital directly, if the claim was sent directly from the hospital, or reimburse you, up to the value of semi-private accommodation.

Out-of-province hospital and medical expenses

If you have supplementary coverage and have a travel-related emergency, contact Europ Assistance (where possible, before incurring expenses) at:

- 1-800-511-4610 (in Canada or the US), or
- 001-800-368-7888 (in Mexico), or
- *202-296-7493 (from elsewhere, call collect).

* Add the long distance code to contact the US.

Europ Assistance will coordinate payments from the provincial Health Care plan and Sun Life for members under the supplementary coverage. You do not need to submit a claim, unless you want to claim for coordination of benefits under another plan.

If you do not contact Europ Assistance:

- get detailed receipts,
- submit expenses to your provincial Health Care plan,
- once the province reimburses you, send Sun Life:
    - a claim form,
    - duplicate receipts (or photocopies), and
    - the provincial statement of payment.

Send in your claim as quickly as possible, because provincial plans have very strict time limits. If claims are late, they may not be paid by the province or Sun Life.

Vision Care benefit expenses

For eyeglasses or contact lenses, you can submit your claim electronically. Just go to www.sunnet.sunlife.com/member/signin/index.asp, sign in with your access ID and PIN, click on "My claims" and then click on "Vision Care e-claim" under the "Submit a claim" tab. You can get an access ID and PIN number by calling Sun Life at 1-800-361-6212.

If you prefer:

- pay the expense and get a receipt,
- complete a claim form, and
- mail both claim and original receipt to Sun Life.

For laser eye surgery:

- pay the expense and get a receipt,
- complete a claim form, and
- mail both claim and original receipt to Sun Life.

Once the next two-year calendar period begins, submit a claim form with a copy of your original receipt and explanation of benefits from Sun Life. You can continue to resubmit the laser surgery expense claim under the regular Health Care Plan until the balance is paid, as long as the person for whom you are claiming remains continuously covered under the Plan.

Prescription drugs, other medical supplies and paramedical services

For other eligible expenses:

- pay the expense and get a receipt,
- complete a claim form, and
- mail both claim and original receipt to Sun Life.

Dental expenses resulting from accidental injury

- Have your dentist complete the appropriate sections of the dental claim form. Make sure that the claim is not sent electronically to the Dental Care Plan.
- Attach the Dental Care claim form to a Health Care claim form and send both to Sun Life.

Coordination of benefits

If you or your dependents are covered for Hospital or Extended Health Care under this plan and another plan, our benefits will be coordinated with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

The plan that does not contain a coordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a coordination of benefits clause.

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

Amounts not paid by the primary plan will be adjudicated on a reasonable and customary basis, up to the eligible amount of the expense.

The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses

Where both plans contain a coordination of benefits clause, claims must be submitted in the order described below.

Claims for you and your spouse should be submitted in the following order:

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order applies:
    - the plan where the person is covered as an active full-time employee.
    - the plan where the person is covered as an active part-time employee.
    - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

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

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

The above order applies in all situations except when parents are separated/divorced and there is no joint custody of the child, in which case the following order applies:

- the plan of the parent with custody of the child.

- the plan of the spouse of the parent with custody of the child.
- the plan of the parent not having custody of the child.
- the plan of the spouse of the parent not having custody of the child.

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

The contract holder can help you determine which plan you should claim from first.

Recovering overpayments

We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

Definitions

Here is a list of definitions of some terms that appear in this group benefits e-booklet. Other definitions appear in the benefit sections.

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

Benefit year January 1 to December 31.

Dentist A person licensed to practise dentistry, and who is operating within the scope of his licence..

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

Hospital An institution designated as such by law for the care and treatment of sick and injured persons which has organized facilities for diagnostic treatment and major surgery and which provides 24 hour nursing services, including beds set aside in such an institution for convalescent care and also including any legally licensed hospital providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis or chronically ill persons. This does not include a nursing home, rest home, home for custodial care of the aged or chronically ill, a sanatorium or a convalescent hospital.

Illness An illness is a bodily injury, disease, mental infirmity or sickness.

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

Hospital

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the retired employee and all dependents covered for Hospital benefits.

Eligible expenses

Eligible expenses are charges for the following services or supplies which are medically necessary and customarily provided in relation to the nature and severity of the illness and which do not exceed the general level of charges in the area where the expense is incurred as determined by Sun Life.

Calendar year maximum

All hospital and extended health care claims incurred in Canada will be subject to a calendar year maximum of $100,000 per eligible claimant, effective March 1, 2016.

Hospital Benefit

Covered percentage – 100%

Charges for room and board in a hospital up to the hospital's semi-private rate excluding hospital charges referred to as coinsurance charges or user fees (including, where permitted by law, any admittance charges).

Proof of claim

Proof of claim must be received by Sun Life not later than 3 months after the end of the benefit year during which the expenses were incurred, unless, in Sun Life's opinion, it was not reasonably possible to submit the claim within this period. In such case, proof of claim must be received by Sun Life as soon as reasonably possible, but not later than 18 months after the end of the benefit year during which the expenses were incurred.

Payment of benefit

Upon receipt of proof of claim that a person while covered incurred an eligible expense, a benefit is paid subject to Limitations, Exclusions and Coordination of benefits.

Each eligible expense is allocated to the benefit year in which it is deemed incurred.

An eligible expense is deemed to be incurred on the date the service is received or on the date supplies are purchased or rented.

Each eligible expense is multiplied by the covered percentage to determine the amount payable, once the eligible expense maximum is applied.

Limitations

Payment is not made for:

1. 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.
2. any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.
3. services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
4. 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.
5. services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

Exclusions

A benefit is not paid for:

1. charges incurred for an illness due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.
2. charges for services and supplies, rendered or prescribed by a person who is normally resident in the patient's home or who is related to the patient by blood or marriage.
3. charges for services or supplies for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of an accident.
4. any service or supply for which there would be no charge in the absence of this coverage.
5. charges for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes.
6. charges for experimental services or supplies, for which substantial evidence provided through objective clinical testing of the service's or supply's safety and effectiveness for the

purpose and under the conditions of the recommended use does not exist to Sun Life's satisfaction.

7. the portion of any charge which is the legal liability of another party.
8. charges for services provided by a doctor licensed and practising in Canada where the person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included under this provision.
9. expenses for benefits which are legally prohibited by the government from coverage.
10. the portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program.
11. the portion of charges for services or supplies provided in a hospital outside of Canada that would normally be payable under a provincial health or hospital plan if the service or supply had been rendered in a hospital.

Extended Health Care

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the retired employee and all dependents covered for Extended Health Care benefits.

Eligible expenses

Eligible expenses are charges for the following services or supplies which are medically necessary and customarily provided in relation to the nature and severity of the illness and which do not exceed the general level of charges in the area where the expense is incurred as determined by Sun Life.

Calendar year maximum

All hospital and extended health care claims incurred in Canada will be subject to a calendar year maximum of $100,000 per eligible claimant, effective March 1, 2016.

Prescription drug deductible

$4 for each prescription or refill

Type 1 – Prescription Drug Benefit

Covered percentage:
– for items 11 and 12: 100% in excess of the deductible
– for all other items: 80% in excess of the deductible.

Drugs or supplies must be prescribed by a doctor or dentist and dispensed by a licensed pharmacist or a doctor.

Charges for:

1. drugs which legally require a prescription and are identified in the Monographs section of the current Compendium of Pharmaceuticals and Specialties as a narcotic, controlled drug, or requiring a prescription.
2. contraceptives prescribed in writing by a doctor.
3. life-sustaining drugs which may not legally 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
   anticholinergic preparations
   antiparkinsonism agents
   anti-arrhythmic agents
   bronchodilators
   glaucoma therapy
   antihyperlipidemic agents
   insulin preparations
   hyperthyroidism therapy
   oral fibrinolytic agents
   parasympathomimetic agents
   potassium replacement therapy
   tuberculosis therapy
   topical enzymatic debriding agents
4. replacement therapeutic nutrients prescribed by an accredited medical specialist for the treatment of an illness excluding allergies or aesthetic ailments, provided that there is no other nutritional alternative to support the life of the person.

5. injectable drugs, including allergy serums administered by injection.
6. compounded prescriptions, regardless of their active ingredients.
7. needles, syringes, and chemical diagnostic aids for the treatment of diabetes (except needles and syringes are not eligible for the 36 month period following the date of purchase of an insulin jet injector device).
8. vitamins and minerals which are prescribed for the treatment of a chronic disease, when in accordance with customary practice of medicine, the use of such products are proven to have therapeutic value and no other alternatives are available to the person**.**
9. drug delivery devices to deliver asthma medication, which are integral to the product, and approved by Sun Life.
10. aerochambers with masks for the deliver of asthma medication for children under age 6.
11. any nicotine resin containing products which require a prescription. The maximum amount payable during each person's lifetime is $1,000.
12. drugs for the treatment of erectile dysfunction. The maximum amount payable is $1,300 per person in a benefit year.
13. drugs used for the treatment of obesity, including injectable vitamins and dietary supplements, prescribed by a doctor when used in conjunction with a weight loss drug program, subject to prior approval. The person needs to be declared obese in accordance with the World Health Organization

Ineligible Expenses

Payment is not made for:

1. drugs which in Sun Life's opinion, are experimental.
2. publicly advertised items or products which, in Sun Life's opinion, are household remedies.
3. vitamins (except injectables), minerals and protein supplements, other than those indicated as eligible expenses.
4. therapeutic nutrients other than those indicated as eligible expenses.
5. any charge for diets and dietary supplements, other than those indicated as eligible expenses.
6. infant foods and sugar or salt substitutes.
7. lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives or emollients.
8. surgical supplies and diagnostic aids.
9. drugs which are used for cosmetic purposes.
10. drugs which are used for a condition or conditions not recommended by the manufacturer of the drugs.
11. expenses incurred under any of the conditions listed under Limitations and Exclusions.
12. over the counter drugs bearing a DIN, whether or not they are prescribed by a doctor.

The payment for a single purchase of a Type 1 eligible expense is limited to the cost of a supply which could reasonably be consumed or used in a 100 day period following such payment.

Generic limit

Unless the doctor specifies in writing that a substitution for the prescribed drug may not be made, any charge in excess of the cost of the lowest priced interchangeable generic product is considered an ineligible expense, regardless of the product actually dispensed.

Other health professionals allowed to prescribe drugs

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Québec drug insurance plan

Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements.

Type 2 – Additional Health Care Benefit

Covered percentage:

– for items 3, 4, 5, 13, 14, 15, 16 and 20 – 100%

– for all other items – 80%

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

Additional Health Care, other than wigs, must be ordered by a doctor.

Charges for:

1. use of a licensed ambulance for local transportation of the person to the nearest hospital qualified to render the necessary medical services.
2. use of a licensed air ambulance for transportation of the person to the nearest hospital qualified to render necessary emergency medical services.
3. the following services outside the person's province of residence for emergency services or referrals provided the charges are in excess of the amount payable by a provincial health insurance plan
   A. room and board in a hospital up to the hospital's ward rate (including where permitted by law, any admittance, coinsurance, or utilization charges).

B. other hospital services (provided out of Canada).

C. out-patient services in a hospital.

D. services of a doctor.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives. Coverage for emergency services is subject to all conditions indicated in this benefit provision under *Out-of-province emergency services* and *Emergency services excluded from coverage*.

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where the person lives, subject to the covered percentage and all conditions applicable to those expenses.

Eligible expenses for emergency services must be incurred within 60 days of the date the person leaves his province of residence. If hospital admittance takes place within such period, in-patient services are covered until the date of discharge.

A referral must be for treatment of an illness and made in writing by a doctor located in the person's province of residence. Services rendered in such cases:

A. must be rendered in Canada if such services (irrespective of any waiting lists) are available in Canada, or may be rendered out of Canada if such services are not available in Canada, and

B. must be services for which the provincial Medicare Plan of the person's province of residence agrees, in writing, to pay benefits to such person as a result of the referral.

For out of Canada emergency services: The maximum amount payable per period of travel is $1,000,000 for each person.

For out of Canada referred services: The maximum amount payable per illness is $25,000 for each person.

4. services, while not confined in a hospital, of a private duty nurse. The maximum amount payable in any benefit year is $15,000 for each person. (A *private duty nurse* is a registered nurse, or nursing assistant, licensed, registered or certified through the respective provincial licensing body or professional organization as the case may be. In the absence of such a registry, this will include a nurse with comparable qualifications as determined by Sun Life.)
5. wigs following total hair loss as the result of an illness. The maximum amount payable during each person's lifetime is $500.
6. rental, or purchase at Sun Life's option, of durable equipment manufactured specially for medical use and which is required for temporary and therapeutic use in the person's private residence. Eligible equipment must be approved by Sun Life and includes, but is not limited to, items such as:

   A. walkers.

   B. hospital beds.

   C. apnea monitors.

   D. alarm systems for enuretic persons.

   Payment will be limited to the cost of non-motorized equipment unless medically proven that the person requires motorized equipment.
7. rental, or purchase at Sun Life's option, of a wheelchair, required for therapeutic use in the person's home. Payment will be limited to the cost of non-motorized equipment unless medically proven that the person requires motorized equipment. Repairs and replacement of a purchased wheelchair are eligible expense, but not within 60 months of the last purchase of a wheelchair.
8. casts, splints, trusses, crutches, cervical collars and braces which contain either metal or hard plastic, excluding dental braces and braces used primarily for athletic use.
9. mammary prostheses following surgery, and their replacements. Replacements are limited to 1 replacement for each prostheses in any period of 24 consecutive months.
10. temporary artificial limbs.

11. artificial eyes and permanent artificial limbs to replace temporary artificial limbs, and their replacements, but not within:
    A. 60 months of the last purchase in the case of a retiree or a dependent over 21 years of age, or
    B. 12 months of the last purchase in the case of a dependent 21 years of age or less,

    unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.
12. elasticized support stockings and elasticized apparel for burn victims, manufactured to the person's specifications or having a minimum compression of 30 millimetres.
13. orthopaedic brassieres. The maximum amount payable in any benefit year is $100 for each person.
14. orthotic inserts for shoes. The maximum amount payable in any benefit year is $300 for each person.
15. orthopaedic shoes which are an integral part of a brace or custom made orthopaedic shoes, including modifications to such shoes, prescribed in writing by a doctor or a podiatrist. The maximum amount payable for each person in any benefit year is the lesser of (i) $150, and (ii) the total charge, less the average cost of regular footwear as determined by Sun Life.
16. hearing aids, other than those in item 21, prescribed in writing by an otolaryngologist, and their repairs. The maximum amount payable in any period of 60 consecutive months is $500 for each person.
17. oxygen and its administration.
18. glucometers, and their repair and replacement, for insulin dependent diabetics and for non-insulin dependent diabetics who are legally blind or colour blind. Repairs and replacements are not permitted within the 60 month period following the date of purchase.
19. insulin pumps and associated equipment, and their repair and replacement, for insulin dependent diabetics when prescribed by a doctor who is associated with a recognized centre for the treatment of diabetics at a university teaching center in Canada. Repairs and replacements are not permitted within the 60 month period following the date of purchase.

20. insulin injector devices for insulin dependent diabetics. The maximum amount payable in any period of 36 consecutive months is $760 for each person.
21. the initial purchase of eyeglasses, contact lenses or hearing aids when required as the direct result of surgery or an accident provided the purchase is made within 6 months after the date of the surgery or accident. This time limit may be extended if, in Sun Life's opinion, the purchase could not have been made within this time frame.
22. colostomy, ileostomy and tracheostomy supplies, and catheters and drainage bags for incontinent, paraplegic or quadriplegic persons.
23. doctor's services where such services are not eligible for reimbursement under the person's provincial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial health insurance plans.

    Where only one province provides reimbursement for a particular service, and that province discontinues the coverage, the issue will be subject to review by the Board of Trustees as to whether coverage will also be discontinued under this Plan.

    Claims for such services, following cessation of provincial coverage, will be held by Sun Life pending the decision of the Board of Trustees.

    Where a province begins reimbursement for a particular service, claims for the service will be held by Sun Life pending a review by the Board of Trustees as to whether the service should be covered under this Plan in the other province and territories.
24. bandages and surgical dressings required for the treatment of an open wound or ulcer.
25. laboratory tests done in a commercial laboratory for diagnosis of an illness (but excluding any tests performed in a doctor's office or a pharmacy).

Out-of-province emergency services

Eligible expenses for emergency services outside the person's province of residence are subject to all the conditions indicated below.

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ Assistance 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 Europ Assistance cannot be made before services are provided, contact with Europ Assistance 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 you are medically stable to return to the province where you live.

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 you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province 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 Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.

4. services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you 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.

Type 3 – Paramedical services

Covered percentage:

– for items 1A, 1B, 1C and 1E – 100%

– for all other items – 80%

Charges for:

1. the following paramedical services (including utilization charges where permitted by law)
   A. services of practitioners licensed as speech therapists or chiropractors and services of a doctor for similar treatment, including x-ray examinations ordered by a chiropractor or a doctor. All practitioners must be licensed, registered or certified through the respective provincial licensing body or professional organization as the case may be. Services of a speech therapist must be ordered by a doctor. The maximum amount payable in any benefit year is $500 per discipline, for each person.
   B. services of a licensed psychologist when ordered by a doctor. The maximum amount payable in any benefit year is $1,000 for each person.
   C. services of practitioners licensed as osteopaths, acupuncturists, podiatrists/chiropodists, naturopaths or massage therapists, including x-ray examinations ordered by each licensed practitioner. All practitioners must be licensed, registered or certified through the respective provincial licensing body or professional organization as the case may be. The maximum amount payable in any benefit year is $300 per discipline, for each person.

D. services of a licensed physiotherapist when ordered by a doctor.

E. services of a doctor or a licensed electrologist for removal of excessive hair from exposed areas of the face and neck when the person suffers from severe emotional trauma as a result of this condition. Such services must be ordered by a psychiatrist or a psychologist. The maximum amount payable for each person is $20 per visit.

Type 4 - Vision Care

1. eye examinations performed by a licensed optometrist. The maximum amount payable every 2 calendar years, with the first 2 year period commencing on January 1, 2010 and ending on December 31, 2011, is for one eye examination for each person.

2. contact lenses or lenses and frames for eyeglasses, and their repairs, or laser eye correction surgery. Supplies must be prescribed in writing by an ophthalmologist or a licensed optometrist and must be dispensed by an ophthalmologist, a licensed optometrist or a qualified optician. Laser eye correction surgery must be performed by an ophthalmologist. The maximum payable every 2 calendar years, with the first 2 year period commencing on January 1, 2010 and ending on December 31, 2011, is $200 for each person. For laser eye surgery only, the maximum payable of $200 can be claimed in every 2 year block until the total cost of the surgery has been reimbursed, provided the claimant remains covered under the Plan.

Type 5 – Dental Care Benefit

Covered percentage – 80%

Charges for:

1. dental services, including braces and splints to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while a person is covered. These services must be received within 12 months of the accident. Sun Life will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the retiree lives. The guide must be the current guide at the time that treatment is received.

2. the following oral surgical procedures performed by a Dentist up to amount specified for the procedure in the provincial Dental Association Fee Guide for a general practitioner which is current on the date of treatment (i) in the province where the service is rendered, if the service is rendered in Canada, (ii) in the province where the person resides, if the person is a resident of Canada and the service is rendered outside of Canada, and (iii) in Ontario, if the person is not a resident of Canada and the service is rendered outside of Canada.

   A. cysts, lesions, abscesses
      (a) biopsy
         (i) soft tissue lesion
         (ii) incision
         (iii) excision
         (iv) hard tissue lesion
      (b) excision of cysts
      (c) excision of benign lesion
      (d) excision of ranula
      (e) incision and drainage
         (i) intra oral - soft tissue
         (ii) intra osseous - (into bone)
      (f) periodontal abscess - incision and drainage
   B. gingival and alveolar procedures
      (a) alveoplasty
      (b) flap approach with curettage
      (c) flap approach with osteoplasty
      (d) flap approach with curettage and osteoplasty
      (e) gingival curettage
      (f) gingivectomy with or without curettage
      (g) gingivoplasty

C. removal of teeth or roots
   (a) removal of impacted teeth
   (b) removal of root or foreign body from max. antrum
   (c) root resection - (apiectomy or apicoectomy)
      (i) anterior teeth
      (ii) bicuspids
      (iii) molars

D. fractures and dislocations
   (a) dislocation - temporo-mandibular joint (or jaw)
      (i) closed reduction
      (ii) open reduction
   (b) fractures - mandible
      (i) no reduction
      (ii) closed reduction
      (iii) open reduction
   (c) fractures - maxillar or malar
      (i) no reduction
      (ii) closed reduction
      (iii) open reduction
      (iv) open reduction (complicated)

E. other procedures
   (a) avulsion of nerve - supra or infra-orbital
   (b) frenectomy - labial or buccal (lip or cheek)
   (c) lingual (tongue)
   (d) repair of antrooral fistula
   (e) sialolithotomy - simple
   (f) sialolithotomy - complicated
   (g) sulcus deepening, ridge reconstruction
   (h) treatment of traumatic injuries
      (i) repair of soft tissue lacerations
      (ii) debridement, repair, suturing
   (i) torus – (bone biopsy)

Proof of claim

Proof of claim must be received by Sun Life not later than 3 months after the end of the benefit year during which the expenses were incurred, unless, in Sun Life's opinion, it was not reasonably possible to submit the claim within this period. In such case, proof of claim must be received by Sun Life as soon as reasonably possible, but not later than 18 months after the end of the benefit year during which the expenses were incurred.

Payment of benefit

Upon receipt of proof of claim that a person while covered incurred an eligible expense, a benefit is paid subject to Limitations, Exclusions and Coordination of benefits.

Each eligible expense is allocated to the benefit year in which it is deemed incurred.

An eligible expense is deemed to be incurred on the date the service is received or on the date supplies are purchased or rented.

The eligible expense is multiplied by the covered percentage to determine the amount payable.

The deductible, if any, is applied against the eligible expense and the result multiplied by the covered percentage to determine the amount payable.

Limitations

Payment is not made for:

1. 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.
2. any portion of the charges for services or supplies over the customary and reasonable charges, in the locality where they are provided.
3. services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
4. 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.
5. services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).

Exclusions

A benefit is not paid for:

1. charges incurred for an illness due to or resulting from any cause for which indemnity or compensation is provided under any Workers' Compensation Act, Criminal Injuries Compensation Act or similar legislation.
2. charges for services and supplies, rendered or prescribed by a person who is normally resident in the patient's home or who is related to the patient by blood or marriage.
3. charges for services or supplies for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of an accident.
4. any service or supply for which there would be no charge in the absence of this coverage.
5. charges for services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport or similar purposes.

6. charges for experimental services or supplies, for which substantial evidence provided through objective clinical testing of the service's or supply's safety and effectiveness for the purpose and under the conditions of the recommended use does not exist to Sun Life's satisfaction.
7. the portion of any charge which is the legal liability of another party.
8. charges for services provided by a doctor licensed and practising in Canada where the person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included under this provision.
9. expenses for benefits which are legally prohibited by the government from coverage.
10. the portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program.
11. the portion of charges for services or supplies, other than those listed in Type 2 items 3 and 4, provided in a hospital outside of Canada that would normally be payable under a provincial health or hospital plan if the service or supply had been rendered in a hospital in Canada.
12. charges for items purchased primarily for athletic use.
13. dental expenses, other than those indicated as eligible expenses.
14. expenses for ambulance services for a medical evacuation which are eligible under the Emergency Travel Assistance Benefit Provision.
15. expenses for repairs or replacement of purchased durable equipment.
16. coinsurance charges or similar charges for hospital care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan and which are not charges made for utilization of semi-private or private accommodation.

Emergency Travel Assistance

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

In this section, *you* means the retired employee and all dependents covered for Emergency Travel Assistance benefits.

General description of the coverage

If you are faced with a medical emergency when travelling outside of the province where you live, Europ Assistance USA, Inc. (*Europ Assistance*) can help.

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 60 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

The Medi-Passport coverage is subject to any maximum applicable to the emergency portion of the Extended Health Care benefit. The emergency services excluded from coverage, and all other conditions, limitations and exclusions applicable to your Extended Health Care coverage also apply to Medi-Passport.

We recommend that you bring your Travel card with you when you travel. It contains telephone numbers and the information needed to confirm your coverage and receive assistance.

Getting help

At the time of an emergency, you or someone with you must contact Europ Assistance. If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance 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.

Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card.

Europ Assistance may arrange for:

On the spot medical assistance

Europ Assistance will provide referrals to physicians, pharmacists and medical facilities.

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ Assistance, will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Europ Assistance will provide translation services in any major language that may be needed to communicate with local medical personnel.

Europ Assistance will transmit an urgent message from you to your home, business or other location. Europ Assistance will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home.

In these cases, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Europ Assistance, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.

Meals and accommodations expenses

If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Europ Assistance will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days.

Europ Assistance will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Europ Assistance, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.

Travel expenses home if stranded

Europ Assistance will arrange and, if necessary, advance funds for transportation to the province where you live:

1. for you, if due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated; or
2. for a child who is under the age of 16, or mentally or physically handicapped, and left unattended while travelling with you when you are hospitalized outside the province where you live, due to a medical emergency.

If necessary, in the case of such a child, Europ Assistance will also make arrangements and advance funds for a qualified attendant to accompany them home. The attendant is subject to the approval of you or a member of your family.

We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.

Travel expenses of family members

Europ Assistance will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the place where you are hospitalized if you are hospitalized for more than 7 consecutive days, and:

1. you are travelling alone, or
2. you are travelling only with a child who is under the age of 16 or mentally or physically handicapped.

We will pay a maximum of $150 a day for the family member’s meals and accommodations at a commercial establishment up to a maximum of 7 days.

Repatriation

If you die while out of the province where you live, Europ Assistance will arrange for all necessary government authorizations and for the return of your remains, in a container approved for transportation, to the province where you live. We will pay a maximum of $5,000 per return.

Vehicle return

Europ Assistance will arrange and, if necessary, advance funds up to $500 for the return of a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from returning the vehicle.

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Europ Assistance will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and Europ Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Europ Assistance will ask you to sign a form authorizing them to act on your behalf.

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association.

The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Limits on advances

Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.

The maximum amount advanced will not exceed $10,000 per person per trip unless this limit will compromise your medical care.

Reimbursement of expenses

If, after obtaining confirmation from Europ Assistance that you are covered and a medical emergency exists, you pay for services or supplies that were eligible for advances, Sun Life will reimburse you.

To receive reimbursement, you must provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. The contract holder can provide you with the appropriate claim form.

Your responsibility for advances

You will have to reimburse Sun Life for any of the following amounts advanced by Europ Assistance:

1. any amounts which are or will be reimbursed to you by your provincial medicare plan.
2. that portion of any amount which exceeds the maximum amount of your coverage under this plan.
3. amounts paid for services or supplies not covered by this plan.
4. amounts which are your responsibility, such as deductibles and the percentage of expenses payable by you.

Sun Life will bill you for any outstanding amounts. Payment will be due when the bill is received. You can choose to repay Sun Life over a 6 month period, with interest at an interest rate established by Sun Life from time to time. Interest rates may change over the 6 month period.

Limits on Emergency Travel Assistance coverage

There are countries where Europ Assistance is not currently available for various reasons. For the latest information, please call Europ Assistance before your departure.

Europ Assistance reserves the right to suspend, curtail or limit its services in any area, without prior notice, because of:

1. a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.
2. the refusal of authorities in the country to permit Europ Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Europ Assistance

Neither Sun Life nor Europ Assistance will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

In an emergency where to call

In an emergency, contact Europ Assistance immediately. (This is a requirement of your Plan). Physicians and hospitals can call to confirm benefits and arrange direct payment.

Europ Assistance's call centre is open 24 hours a day.

- 1-800-511-4610 (in Canada or the US), or
- 001-800-368-7888 (in Mexico), or
- *202-296-7493 (from elsewhere, call collect), or
- Toll free dialling is not available in Cuba. Use international operator, or
- Fax: *202-331-1528
- E-mail: ops@europassistance-usa.com

* Add the long distance code to contact the US