

your **group**
benefits

University of British Columbia

CUPE Local 116

Contract Number 025205
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General Information

About this booklet

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

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

If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority.

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

The contract holder, University of British Columbia (*UBC*), self-insures all benefits. This means UBC has the sole legal and financial liability for all benefits and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing.

Information at your fingertips

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

We're on the Internet

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

Our address is: www.sunlife.ca

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the conditions outlined in your employer's **UBC Employee Group Eligibility Matrices for Group Benefits**. This information is located on UBC's HR-Benefits website for your particular group.

For Extended Health Care, you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

The waiting period for your group plan is as outlined in your employer's **UBC Employee Group Eligibility Matrices for Group Benefits**. This information is located on UBC's HR-Benefits website for your particular group.

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

You will become eligible for retiree or survivor benefit coverage under your contract, 20605, the day after your coverage terminates, provided you apply for benefits within 31 days from the date of eligibility.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada or the United States.

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

Your child and your spouse's child (other than a foster child), who is not married or in any other formal union recognized by law, and who is:

- under 19, or
- age 19 or over but under age 25 who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) and is entirely dependent on you for financial

support.

A child for whom you or your spouse is the primary caregiver and who has been granted custody and control, is also considered an eligible dependent, provided the child is entirely dependent on you or your spouse for financial support and is:

- under 19, or
- age 19 or over but under age 25 who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada).

A dependent child's coverage will terminate at the end of the month the child attains the limiting age.

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

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

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

Enrolment

You have to enrol to receive coverage. To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer. For a dependent to receive coverage, you must request dependent coverage.

If you or your dependents are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

When coverage begins

Your coverage begins as outlined in the employer's **UBC Employee Group Eligibility Matrices for Group Benefits**.

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

Dependent coverage begins as outlined in the employer's **UBC Employee Group Eligibility Matrices for Group Benefits**.

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.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, your employment status may change, or your employer may change the group plan. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exceptions apply if the result of the change is an increase in coverage:

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

Updating your records

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

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- change of dependents.
 - change of name.

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

- the last day of the month in which your employment ends or you retire or the employment status changes.
- the end of the month prior to the effective date of the UBC Staff Pension Plan or CUPE 116 Hourly Pension Plan retirement income/benefit option(s) elected by you, if you continue to work past your normal retirement date.
- the end of the calendar year in which you reach the maximum pensionable age as defined by the Income Tax Act (Canada). The maximum pensionable age at January 1, 2008 as defined by the Income Tax Act is 71.
- the date you are no longer actively working and maintaining coverage.
- the date the benefit provision under which you are covered terminates.
- the date you no longer satisfy the eligibility requirements (as described in the **Eligibility Matrices**).
- the date you enter the armed forces of any country on a full-time basis.

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

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

The termination of coverage may vary from benefit to benefit. For

information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

However, if you die while covered by this plan, Extended Health Care and Dental Care coverage for your dependents will continue up to the last day of the month in which you die.

Services provided by a doctor or dentist Many of the provisions under this plan require the involvement of a doctor or dentist. When a doctor's or dentist's involvement is required, the doctor or dentist must be a person other than the employee, a person who is ordinarily a resident in the patient's home or a person who is related to the patient by blood or marriage.

Making claims Sun Life is dedicated to processing your claims promptly and efficiently. The necessary claim forms are available from your Payroll Office in the Department of Financial Services. Alternatively, you can download them from the Human Resources website at www.hr.ubc.ca/benefits or access them through the Sun Life Plan Member site at www.mysunlife.ca (after you have ascertained your Access Id and PIN).

Please ensure original receipts are attached to your claim form and we recommend that you keep copies of both your original receipts and claim form. Photocopies of receipts are only acceptable when coordinating a claim and must be accompanied by the explanation of benefits from the other carrier.

Claims may be submitted electronically for some expenses.

If you require further information concerning your benefits, please call the Sun Life Customer Care Centre at 1 800 361-6212. You will need to provide your contract number (025205) and certificate number (member ID, member ID = UBC employee number) for personal identification. For dental claims, we will access the Standard Generic claim form from your dentist or you may choose to submit your dental claim online through the Sun Life Plan Member site.

Legal actions

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

Coordination of benefits

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

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

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

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

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

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

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

2. the plan where the person is covered as a dependent (for example, if you are covered as a dependent under your spouse's plan).

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

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

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

1. the plan where the child is covered as an employee.
2. the plan where the child is covered under a student health or dental plan provided through an educational institution.
3. the plan of the parent with custody of the child.
4. the plan of the spouse of the parent with custody of the child.
5. the plan of the parent not having custody of the child.
6. the plan of the spouse of the parent not having custody of the child.

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

Your employer can help you determine which plan you should claim from first.

Medical examination	We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.
Recovering overpayments	We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.
Definitions	Here is a list of definitions of some terms that appear in this employee benefits booklet. Other definitions appear in the benefit sections.
<i>Accident</i>	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
<i>Actively working</i>	We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day.
<i>Doctor</i>	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
<i>Employer</i>	The employer is the plan sponsor. The employer also has paymaster arrangements with other employers.
<i>Illness</i>	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.
<i>Normal retirement date for totally disabled employee</i>	The normal retirement date is deemed to be the last day of the month in which you attain age 65.
<i>Paymaster employers</i>	Paymaster employers are those employers for which UBC acts as paymaster by administering benefits and payroll on their behalf. As such, UBC is the Benefit Plan Sponsor.
<i>We, our and us</i>	We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care (Medicare Supplement)

Plan administrator Sun Life Assurance Company of Canada administers this benefit, with the exception of the Prior Authorization Drug Program, which is administered by Cubic Health.

General description of the coverage The contract holder has the sole legal and financial liability for this benefit. Sun Life and Cubic Health only act as administrators on behalf of the contract holder.

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

Extended Health Care coverage pays the reasonable and customary charges for eligible services or supplies for you that are medically necessary for the treatment of an illness and have been recommended or prescribed by a doctor. However, there are additional eligibility requirements that apply to some drugs (see *Prior Authorization Drug Program* for details).

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

This plan and its administrative practices were developed based on the Canada Health Act which requires all provinces and territories to cover the cost of all medically necessary hospital services, including medically necessary in-patient and out-patient services such as drugs administered in a hospital. This means that if a covered person is administered a drug in a hospital, either through in-patient or on an out-patient basis, the cost of the drug will not be eligible for reimbursement under this plan. There is also no provision in our plan to support the reimbursement of administration fees (i.e. a fee charged to a patient to administer a drug in a hospital either through in-patient or on an out-patient basis). The person is encouraged to seek coverage

for such hospital prescription drugs from the provincial government or health authority.

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

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

Deductible

The deductible is the portion of claims that you are responsible for paying.

The deductible is \$25 each benefit year for each person up to a maximum of \$25 per family.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

If 2 or more members of your family suffer injuries in the same accident, only one individual deductible is applied in each benefit year against all eligible expenses for those injuries.

If all or part of the deductible is satisfied within the last 3 months of the benefit year, your deductible for the next benefit year will be reduced by this amount.

Reimbursement level For all eligible expenses, the reimbursement levels are described below.

However, for prescription drugs, in-province hospital, medical services and equipment and paramedical services combined, the reimbursement levels described below apply to the first \$1,000 of paid claims per

person per benefit year. Thereafter, any eligible expenses per person per benefit year are paid at 100%.

Lifetime maximum benefit

Under Extended Health Care, the maximum amount we will pay for any person is \$2,000,000.

Prescription drugs

Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation* and meet the additional eligibility requirements that apply to some drugs under the Prior Authorization Drug Program (see *Prior Authorization Drug Program* for details).

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist:

- drugs that legally require a prescription, including oral contraceptives and non-oral contraceptive devices.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- treatments for weight loss, ordered in writing by a doctor with an indication of duration of treatment and body mass index.
- colostomy supplies.
- varicose vein injections.
- B12 injections for the treatment of pernicious anemia.
- non-oral contraceptive devices that do not require a prescription.
- uracyst treatments. This does not include the cost of the health profession for administering the treatment.

- vaccines, up to a maximum of \$300 per person per benefit year.

We will also cover the cost of products to help a person quit smoking that have a Drug Identification Number (DIN) and have been approved under *Drug evaluation*, or that have a Natural Product Number (NPN), up to a maximum of \$300 per person in a benefit year, provided that they are prescribed by a doctor or dentist and obtained from a pharmacist.

After you pay the deductible, we will cover the above drugs and supplies as follows:

- 85% for items listed in the BC Pharmacare Drug Formulary.
- 70% for items that are not included in the BC Pharmacare Drug Formulary.

Payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor.

We will not pay for the following, even when prescribed:

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- proteins and food or dietary supplements.
- hair growth stimulants.
- drugs for the treatment of infertility.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- any drug, vaccine, item or service classified as preventative treatment or administered for preventative purposes, HCG

injections and general anaesthetic.

- natural health products, whether or not they have a Natural Product Number (NPN), except as otherwise provided under the list of eligible expenses above.

In addition, we will not cover the cost of biologic drugs if the British Columbia provincial plan covers the biosimilar according to the BC PharmaCare Biosimilars Initiative. If there is a medical reason requiring you to take the biologic, then you and your doctor need to complete and submit an exception form. The plan administrator will review this form to assess medical necessity.

Drug evaluation The following drugs will be evaluated and must be approved by us to be eligible for coverage:

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

Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval.

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

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

<i>Drug substitution limit</i>	Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.
<i>Prior Authorization Drug Program</i>	<p>The Prior Authorization (PA) Drug Program requires you to meet a defined set of evidence-based, clinical criteria related to a given medical condition before coverage of a specific PA Drug is approved.</p> <p>A PA Drug is defined as a drug product that has an annual cost of \$5,000 or more for a treatment period of one (1) year or less and which is typically prescribed by an appropriate specialist in a given therapeutic area. A PA Drug could also include specific products that cost less than \$5,000 per year where there are safety concerns that can be mitigated with a PA process.</p> <p>A PA Drug requires you to provide written consent to an independent clinical case evaluator, Cubic Health in order to obtain any relevant personal medical information from your health care professional team (i.e. physician(s), pharmacist(s), nurse practitioner(s), case manager(s), etc.) as needed to make a coverage decision.</p> <p>A PA Drug will have a maximum initial approval period of one (1) year. Where applicable, that will be communicated at the time of any approval. A renewal form will need to be filled out prior to the end of the coverage period in order to be considered for an extension of the approval. An initial PA Drug approval for a given product does not guarantee approval at renewal time. Renewals are based on demonstrated safety and clinical effectiveness of the product for you, and your appropriate adherence to therapy.</p> <p>A specific PA Drug may not be covered for you if:</p> <ul style="list-style-type: none">■ it has been determined that you have not attempted an adequate trial of clinically appropriate alternative therapy (ies) for the same condition.■ the requested dosing is clinically inappropriate.■ it is being used for an underlying condition that is not approved

by Health Canada.

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

The plan retains the right to require an adequate trial of clinically appropriate alternative therapy (ies) before a requested PA Drug is approved and reimbursed under the plan.

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

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

Grand-parenting of drugs reimbursed prior to May 6, 2018 – if a PA Drug was reimbursed under an UBC extended health plan in the twelve month period prior to the effective date of this program, you will automatically be grand-parented and will not be required to apply for prior authorization. However, if there is a requirement to change an existing PA Drug, or add another PA Drug to your medication regimen, you will be required to apply for prior authorization for that drug.

<i>Other health professionals allowed to prescribe drugs</i>	We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.
Hospital expenses in your province	<p>We will cover 80% of the costs for hospital care in the province where you live, after you pay the deductible.</p> <p>We will cover the difference between the cost of a ward and a semi-private or a private hospital room.</p> <p>A <i>hospital</i> is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely or chronically ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.</p>
Hospice	<p>We will cover 80% of the cost of room and board in a hospice, after you pay the deductible, up to a maximum of \$40 per day and a lifetime maximum of 60 days per person.</p> <p>For purposes of this plan, a <i>hospice</i> is a facility licensed to provide palliative and supportive care for terminally ill patients.</p>
Expenses out of your province	<p>We will cover emergency services while you are outside the province where you live.</p> <p>We will cover the cost of:</p> <ul style="list-style-type: none">■ a semi-private hospital room.■ other hospital services provided outside of Canada.■ out-patient services in a hospital.■ the services of a doctor. <p>Emergency expenses for all other services or supplies eligible under</p>

this plan are also covered when they are incurred outside the province where you live, subject to the reimbursement level and all conditions applicable to those expenses.

Emergency services We will pay 100% of the cost of covered emergency services after you pay the deductible.

We will only cover services obtained within 365 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered for 90 days except where transportation would endanger the life of the patient, in which the 90 day limit will be extended.

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.

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

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, AZGA Service Canada Inc. (*Allianz Global Assistance*).

In the **USA** and **Canada**, call: 1 800 511-4610

From anywhere else: 1 519 514-0351

Call collect through an international operator.

Fax: 1 519 514-0374

All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Allianz Global 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 Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global 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:

- 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.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Allianz Global Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- 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.
- 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.

Medical services and equipment

We will cover 80% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor or nurse practitioner if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order or a nurse practitioner's order if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services). All services require a preauthorization for expenses in excess of \$5,000.

- In-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. There is a limit of 720 hours per person per benefit year.
- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. There is a limit of \$25,000 per person during any 3 consecutive benefit years.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Expenses incurred outside Canada

for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- contact lenses or intraocular lenses following a cataract surgery, if the covered person's provincial plan prohibits payment, limited to a maximum of 1 pair per lifetime.
- wigs as a result of medical treatment or injury, up to a lifetime maximum of \$500 per person. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- grab bars for toilets, showers and beds that are medically necessary and purchased from a medical supplier. For expenses incurred for grab bars, coverage is limited to the reasonable and customary charges.
- TENS (transcutaneous electric nerve stimulators) and TEMS (transcutaneous electric muscle stimulators).
- casts, splints, trusses, braces, cane, cane tips, walkers or crutches excluding elastic or foam supports.

- breast prostheses required as a result of surgery.
- surgical brassieres required as a result of surgery, up to a maximum of \$150 per person in a benefit year.
- artificial limbs and eyes.
- stump socks, up to a maximum of \$200 per person in a benefit year.
- elastic support stockings, including pressure gradient hose, with 20 – 29 mm Hg compression, up to a maximum of 2 pairs per person in a benefit year.
- pressure gradient hose, with 30 – 40 mm Hg compression, no maximum.
- custom-made orthotic inserts for shoes, excluding arch supports, when prescribed by a doctor or nurse practitioner if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, podiatrist or chiropodist, up to a maximum of \$200 in a benefit year for a person under age 19 or \$400 in a benefit year for any other person. A doctor's referral or a nurse practitioner's referral (if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services) is required once every 5 years for a person with chronic conditions.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor or nurse practitioner if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, podiatrist or chiropodist, up to a maximum of \$200 in a benefit year for a person under age 19 or \$400 in a benefit year for any other person. A doctor's referral or a nurse practitioner's referral (if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services) is required once every 5 years for a person with chronic conditions.

- hearing aids or hearing assisted devices and batteries (including replacements), prescribed by an ear, nose and throat specialist, up to a maximum of \$900 per person over a period of 5 benefit years. Repairs are included in this maximum.
- radiotherapy or coagulotherapy with a pre-authorization.
- oxygen, plasma and blood transfusions.
- aerochamber with a pre-authorization.
- catheter with a pre-authorization.
- One (CPAP) constant positive airway pressure machine or one oral appliance used to treat sleep apnea in any 3 year period, with a pre-authorization and provided sleep apnea has been diagnosed. Oral appliances are further subject to a maximum of \$2,400 per person in any 3 year period.
- cystic fibrosis equipment with a pre-authorization.
- dialysis machine with a pre-authorization.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- inhalation appliance/device for drug administration and Maxi Mist nebulizer when required for chronic lung disorder.
- cardiac screener.
- insulin pump and maintenance.
- breast pumps, when ordered by a doctor or nurse practitioner if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services.
- elevated toilet seats, bath rails, shower chairs, bath benches, bath chairs, bedpan, safety frame for toilet, tub transfer bench and urinals.

- wheeled/shower commodes, up to a maximum of \$2,000 per person every 3 benefit years.
- Continuous Glucose Monitor (CGM) receivers, transmitters or sensors, for persons diagnosed with Type 1 diabetes, up to a combined maximum of \$4,000 per person per benefit year. You must provide us with a doctor's or nurse practitioner's note, if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services, confirming the diagnosis.

Paramedical services

We will cover 80% of the costs after you pay the deductible, up to the maximums listed below per person per benefit year:

- licensed speech therapists, osteopaths (this category of paramedical specialists also includes osteopathic practitioners), acupuncturists, chiropractors, naturopaths, homeopaths, audiologists, dieticians, occupational therapists, podiatrists or chiropodists up to a combined maximum of \$600.
- licensed physiotherapists or massage therapists (when ordered by a doctor or nurse practitioner if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services), up to a combined maximum of \$750.

Licensed massage therapists require a doctor's or a nurse practitioner's referral (if the applicable provincial legislation permits nurse practitioners to prescribe or order certain supplies or services) every 12 months. We will also accept referrals for pregnant women from midwives, who are registered with a provincial body governing midwives in Canada.

We will cover 100% of the costs after you pay the deductible, up to the maximums listed below per person per benefit year:

- registered/licensed clinical psychologists, or registered/licensed social workers, or clinical counsellors who are active members of

a provincial association which is approved by Sun Life, up to a combined maximum of \$2,500. This maximum includes psychological testing.

All of the above practitioners must be licensed to practice where that practice is located and services must be received in Canada or the United States. All receipts submitted for reimbursement must include all the following information:

- date(s) of service.
- name of patient.
- name of practitioner.
- credentials and/or qualifications of provider as well as professional affiliations with any regulatory body or society, i.e. Canadian Naturopathic Association.
- license number (RIPP = Registered in Province of Practice).
- amount (total cost per visit or per hour).
- breakdown of charges.
- rate per hour if the visit is longer than one hour.

Handwritten receipts will be accepted as long as all of the above details are provided on the receipt.

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

We will cover the cost of contact lenses, eyeglasses, prescription sunglasses or laser eye correction surgery. Contact lenses, eyeglasses or prescription sunglasses must be prescribed by an ophthalmologist or licensed optometrist and obtained from an ophthalmologist, licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

We will also cover eye exams.

We will cover 100% of these costs after you pay the deductible, up to a maximum of \$400 in any 24 month period. At any given time, the amount you are eligible to claim is the maximum of \$400, less the amount of any benefit which has been paid to you during the previous 24 months.

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

When coverage ends Extended Health Care coverage will end on the earlier of the following dates:

- the last day of the month in which your employment ends or you retire or the employment status changes.
- the end of the month prior to the effective date of the UBC Staff Pension Plan or CUPE 116 Hourly Pension Plan retirement income/benefit option(s) elected by you, if you continue to work past your normal retirement date.
- the end of the calendar year in which you reach the maximum pensionable age as defined by the Income Tax Act (Canada). The maximum pensionable age at January 1, 2008 as defined by the Income Tax Act is 71.

Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- services or supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home or who is related to the

patient by blood or marriage.

- services that Sun Life considers ineligible (examples of these services are such as but not limited to services of Victorian Order of Nurses or graduate or license practical nurses, services of religious or spiritual healers, services of visual therapists, services of ergonomists, services and supplies for cosmetic purposes, public ward accommodation or rest cures).
- charges for completions of forms or written reports, communication costs, delivery and mailing or handling charges, interest or late payments charges, non-sharable or capital costs levied by local hospitals.
- charges for pre-existing conditions requiring continuous or routine medical care while outside your province of residence.
- hospital out-patient fees and user fees.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, personal comfort items, items purchased for athletic use, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- 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.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made

in the absence of this coverage.

- enuresis equipment and Mozes Detector.
- traction kit.
- ear plugs.
- blood sampling.
- ultrasound.
- osteopath, chiropractor, podiatrist or chiropodist x-ray examinations.
- services of a kinotherapist, reflexologist, sexologist, sex therapist and shiatsu specialist.

We will not pay benefits when the claim is for an illness resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

Integration with government programs

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

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

- whether you have made an application to the government program,
- whether coverage under this plan affects your eligibility or

entitlement to any benefits under the government program, or

- any waiting lists.

**When and how to
make a claim**

To submit a claim, complete the claim form (for further information on making claims, please refer to the general information section on making claims).

In order for you to receive benefits, we must receive the claim no later than the earlier of:

- December 31 of the benefit year following the year during which you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage.

Emergency Travel Assistance

General description of the coverage

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

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

If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (*Allianz Global 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 services that you obtain within 365 days of leaving the province where you live. If hospitalization occurs within this period, in-patient services are covered for 90 days except where transportation would endanger the life of the patient, in which the 90 day limit will be extended.

A Travel card may be printed off the Sun Life website www.mysunlife.ca or from your Payroll Office in the Department of Financial Services.

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 Allianz Global Assistance:

In the USA and Canada, call: 1 800 511-4610

From anywhere else: 1 519 514-0351

Call collect through an international operator.

Fax: 1 519 514-0374

If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global 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.

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

As soon as Allianz Global Assistance is notified that you have a medical emergency, its staff, or a physician designated by Allianz Global 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, Allianz Global Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

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

Allianz Global Assistance will transmit an urgent message from you to your home, business or other location. Allianz Global Assistance will

keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility

Allianz Global 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, Allianz Global Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Allianz Global 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, Allianz Global 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.

Allianz Global 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 Allianz Global 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

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

- 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
- 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, Allianz Global 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

Allianz Global 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:

- you are travelling alone, or
- 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, Allianz Global 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

Allianz Global 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, Allianz Global 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 Allianz Global Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Allianz Global 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 Allianz Global 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. Your employer 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 Allianz Global Assistance:

- any amounts which are or will be reimbursed to you by your provincial medicare plan.
- that portion of any amount which exceeds the maximum amount of your coverage under this plan.
- amounts paid for services or supplies not covered by this plan.
- 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 Allianz Global Assistance is not currently available for various reasons. For the latest information, please call Allianz Global Assistance before your departure. Please consult the telephone numbers on the Travel card.

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

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

Liability of Sun Life or Allianz Global Assistance

Neither Sun Life nor Allianz Global 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.

Dental Care

**General description
of the coverage**

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

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

Dental Care coverage pays for eligible expenses that you incur for dental procedures provided by a licensed dentist, denturist, dental hygienist and anaesthetist while you are covered by this group plan.

For each dental procedure, we will only cover reasonable expenses. We will not cover more than the fee stated in the Dental Association Fee Guide for general practitioners in the province where the treatment is received. Payments will be based on the current guide at the time the treatment is received.

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, then the fee guide used will be the Dental Association Fee Guide for general practitioners as stated above where the treatment is received plus 10%.

When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

When deciding what we will pay for a procedure, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem and not as a

separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Benefit year maximum

Unlimited

Orthodontic procedures and implants are not included in the benefit year maximum. Separate maximums apply

Implant maximum

We will not pay more than \$1,500 per implant payable once the final implant prosthesis is inserted.

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is \$3,000.

Predetermination

We suggest that you send us an estimate, before the work is done, for any major treatment or any procedure that will cost more than \$500. Orthodontic treatment plans must be submitted. You should send us a completed dental claim form that shows the treatment that the dentist is planning and the cost. Both you and the dentist will have to complete parts of the claim form. We will tell you how much of the planned treatment is covered. This way you will know how much of the cost you will be responsible for before the work is done.

Preventive dental procedures

Your dental benefits include the following procedures used to help prevent dental problems. They are procedures that a dentist performs regularly to help maintain good dental health.

We will pay 100% of the eligible expenses for these procedures.

- Oral examinations* 2 complete examinations per lifetime.
- Treatment planning and case presentation, limited to 4 units of 15 minutes per benefit year.
- Recall and new patient examinations, combined maximum of 2 per person per benefit year.
- Specific examinations, combined maximum of 2 per person per benefit year.
- Emergency examinations.
- X-rays* 1 complete series of x-rays every 3 years.
- Bitewing x-rays or x-rays to diagnose a symptom or examine progress of a particular course of treatment.
- 1 panorex every 5 years.
- Other services* Required consultation with the patient.
- Required consultations with another dentist.
- Pulp vitality tests, limited to one unit of time per quadrant every 6 months.
- Diagnostic models, unmounted, trimmed, limited to one set in a benefit year.
- Polishing (cleaning of teeth) and topical fluoride treatment, up to a maximum of 2 per benefit year.
- Emergency or palliative services.
- Removal of impacted teeth and related anaesthesia.
- Provision of fixed space maintainers.
- Pit and fissure sealants and preventative restorative resins, once per

tooth every 2 years.

Basic dental procedures

Your dental benefits include the following procedures used to treat basic dental problems.

We will pay 100% of the eligible expenses for these procedures.

Fillings Amalgam fillings (silver), composite or acrylic (white fillings), or equivalent.

Extraction of teeth Removal of teeth, except removal of impacted teeth (*Preventive dental procedures*).

Basic restorations Prefabricated metal or plastic restorations (including stainless steel crowns), when a permanent crown is not being installed – once per tooth every 2 years. This procedure includes pulp cap, sedative base, local anaesthesia, occlusal adjustment, removal of decay or existing restoration, and cementation of crown.

Endodontics Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

Periodontics Treatment of disease of the gum and other supporting tissue:

- scaling and root planing (tartar removal), limited to 15 units of 15 minutes (1 unit = 15 minutes) per person in a benefit year.
- gingival curettage, limited to 1 gingival curettage per site per benefit year.
- 2 bruxism appliances every 5 years.
- oral manifestations, oral mucosal disorders.
- occlusal equilibration and adjustments.

Oral surgery Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*) and implant related surgery (*Major dental procedures*). You are covered for anaesthesia only when you have eligible complicated oral surgery.

Rebase or reline Rebase or reline of an existing partial or complete denture. You are covered for 2 of these in any 24 month period.

<i>Tissue conditioning</i>	You are covered for 4 of this procedure every 5 years.
<i>Repair</i>	Repair of bridges or dentures.
<i>Other services</i>	Tissue grafts. Bone grafts.
Major dental procedures	Your dental benefits include the following procedures used to treat major dental problems. We will pay 70% of the eligible expenses for these procedures.
<i>Major restorations</i>	Inlays and onlays. Crowns other than prefabricated metal restorations (<i>Basic dental procedures</i>). All major dental procedures are limited to once every 5 years from the date of insertion when the same tooth is involved.
<i>Crowns</i>	This procedure includes treatment planning, occlusal records, local anaesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, occlusal adjustments, and cementation. It does not include porcelain or porcelain fused to metal for molar teeth. Crowns are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.
<i>Prosthodontics</i>	Construction and insertion of bridges or standard dentures. Charges for a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless: <ul style="list-style-type: none">■ it is needed to replace a bridge or standard denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.■ it is needed to replace a transitional denture which was inserted

shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Implants Implants, including surgery charges, subject to any limitations that would have applied under this plan to a tooth supported crown or a non implant related prosthesis, respectively, if there had been no implant.

The maximum amount we will pay for implants and related surgery is \$1,500 per person, payable once the final implant prosthesis is inserted.

Orthodontic procedures

Your dental benefits include the following procedures used to treat misaligned or crooked teeth.

We will pay 65% of the eligible expenses for these procedures.

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is \$3,000.

Coverage includes orthodontic examinations, including orthodontic diagnostic services and fixed or removable appliances such as braces.

The following orthodontic procedures are covered:

- interceptive, interventive or preventive orthodontic services, other than space maintainers (*Preventive dental procedures*).
- comprehensive orthodontic treatment, using a removable or fixed appliance, or combination of both. This includes diagnostic procedures, formal treatment and retention.

When coverage ends Dental Care coverage will end on the earlier of the following dates:

- the last day of the month in which your employment ends or you retire or the employment status changes.
- the end of the month prior to the effective date of the UBC Staff Pension Plan or CUPE 116 Hourly Pension Plan retirement income/benefit option(s) elected by you, if you continue to work past your normal retirement date.

- the end of the calendar year in which you reach the maximum pensionable age as defined by the Income Tax Act (Canada). The maximum pensionable age at January 1, 2008 as defined by the Income Tax Act is 71.

Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends

If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit.

We will not pay for services or supplies that are not usually provided to treat a dental problem.

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- services or supplies provided by a person who is ordinarily a resident in the patient's home or who is related to the patient by blood or marriage.
- supplies usually intended for sport or home use, for example,

mouthguards.

- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- transplants, and repositioning of the jaw.
- experimental treatments.

We will also not pay for dental work resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- teeth malformed at birth or during development.
- participation in a criminal offence.

When and how to make a claim

To submit a claim, complete the claim form (for further information on making claims, please refer to the general information section on making claims). The dentist will have to complete a section of the form. Claims may be submitted electronically for some expenses.

In order for you to receive benefits, we must receive a claim no later than the earlier of:

- 1 year after the date in which you incur the expenses, or
- 90 days after the end of your Dental Care coverage.

We can require that you give us the dentist's statement of the treatment received, pre-treatment x-rays and any additional information that we consider necessary.

Health Spending Account

General description of the coverage

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

It pays for services or supplies described in this section under *Eligible expenses*.

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

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

The benefit year is from January 1 to December 31.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

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

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits

cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year following the benefit year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

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

Continuation of coverage for dependents

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

Plan credits

\$250 on the commencement of each benefit year.

Effective January 1, 2020 – This amount increases to \$350 per benefit year.

Eligible expenses

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

Drugs

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

Eyeglasses

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

<i>Deductibles and coinsurances</i>	<ul style="list-style-type: none"> ■ deductible and coinsurance amounts under medical or dental plans.
<i>Licensed practitioners (fee for services)</i>	<ul style="list-style-type: none"> ■ acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapists.
<i>Dental care</i>	<ul style="list-style-type: none"> ■ preventative, diagnostic, restorative, orthodontic and therapeutic care.
<i>Attendant care</i>	<ul style="list-style-type: none"> ■ remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months. ■ remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.
<i>Facilities</i>	<ul style="list-style-type: none"> ■ amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future. ■ payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.
<i>Hospitals</i>	<ul style="list-style-type: none"> ■ payments to a public or licensed private hospital.

Devices and supplies

- artificial eyes.
- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of \$1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.

- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe and prolonged mobility restriction.
- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind

individuals to enable them to read print.

- orthopaedic shoe or boot, or an insert for a shoe or boot, made to order for an individual in accordance with a prescription to overcome a physical disability of the individual.
- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
- costs of medical services and supplies outside of the province of

residence.

- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in diagnosis.
- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
 - equivalent medical services are not available locally.
 - the route is reasonably direct.
 - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

If you or your eligible dependents have coverage under another plan, you should submit your claims to the other plan first. Once benefits

**When and how to
make a claim**

have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

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

In order for you to receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses,
or
- the end of your Health Spending Account coverage.

Respecting your privacy

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

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