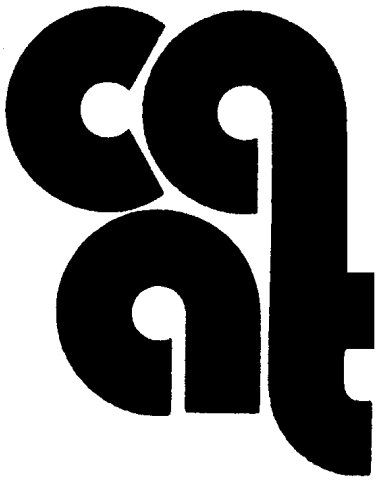

Your Benefits

EMPLOYEE BENEFITS

for

Support Staff Employees of the Ontario Colleges of Applied Arts and Technology

Contract Number 50834
Effective December 1, 2006

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Section 1 - General Information

About this booklet

This booklet has been developed for you and your family by individuals currently on the Support Staff Joint Insurance Committee (JIC) who represent the Ontario Public Service Employees Union (OPSEU), the Colleges of Applied Arts and Technology (CAAT), the College Compensation and Appointments Council (the Council), and representatives from the Insurance Company, Sun Life.

The information contained in this booklet will not in any way diminish current benefit levels in effect as of the date of printing.

The information in this booklet is important to you and should be kept in a safe place. It describes all group insurance benefits available to you (both mandatory and voluntary), explains your entitlements and various administrative issues relating to the Group Insurance Benefit Program. For confirmation of the specific benefit coverage you have elected, please refer to your copy of your Group Insurance Benefits Positive Enrolment Form or contact your college's benefits plan administrator.

It is important to note that this booklet is only a summary of your group contract. It is not a legal document. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority and the Insurance Company will follow the group contract when making a decision to pay a claim.

Benefits described in the booklet are applicable only if you and your Dependent(s) are insured according to the records maintained for the group contract. If you have any questions about the information in this employee benefits booklet, or if you need additional information about your group benefits, please contact your College's Benefits Administrator or Local Union Representative.

About the Group Insurance Benefits Program

The Group Insurance Benefit Program and the cost-sharing arrangements provided to the CAAT Support Staff Employee Group are a result of negotiations and are set out in the Support Staff Collective Agreement.

Section 2 - Roles and Responsibilities

College Compensation and Appointments Council ***(Contract Holder)***

The Council is the Contract Holder on behalf of the Colleges, and is responsible to ensure that the terms of the group contract are adhered to by the Insurance Company and the Colleges.

Joint Insurance Committee (JIC)

The Support Staff JIC consisting of representatives of OPSEU, CAAT and the Council has been established under the Terms of Reference found in Appendix A of the Support Staff Collective Agreement. The committee meets on a regular basis to discuss Group Insurance Benefits matters.

Responsibilities of the JIC

The duties of the Committee include the review of contentious claims and recommendations thereon, when such claim problems have not been resolved through the existing administrative procedures.

Colleges ***(Administrators)***

The Colleges of Applied Arts and Technology have the responsibility to maintain all records regarding an employee's coverage, ensure the rules contained in the group contracts are adhered to, and to communicate the provisions of the group contract to employees. Each College has a designated individual(s) in the Human Resources Department and/or Payroll Services who is responsible for the Group Insurance Benefit Program.

Sun Life ***(Insurance Company)***

The Insurance Company adjudicates and pays claims in accordance with the provisions in the group contract between Sun Life and the Council on behalf of the Colleges.

Employee

You are responsible to:

- know what your benefits are.
- follow the claims submission processes, providing the information requested.
- be an educated consumer.
- keep Human Resources informed about changes that may affect the status of your benefits.

OPSEU
(the employee's representative)

- represent employees covered by the Support Staff Collective Agreement on matters relating to Group Insurance Benefits.
- educate members about benefits.
- communicate with the Contract Holder (the Council) on matters relating to the Group Insurance Benefits.
- participate with the Council in discussions about Group Insurance Benefit issues through the Joint Insurance Committee (JIC) in accordance with the Terms of Reference of the Support Staff JIC as outlined in the Collective Agreement.

Section 3 - Definitions

Actively At Work

The employee is considered to be actively working if the employee is performing all the usual and customary duties of the job with the College for the scheduled number of hours. This includes non-working days and paid vacation if the employee was actively working on the last scheduled working day.

Benefit Year

September 1 to August 31. (Applicable to Vision and Hearing Care only).

Calendar Year

January 1 to December 31. (Applicable to Extended Health Care and Dental Care).

Dentist

A person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practising of dentistry, and who is operating within the scope of the issued licence. The definition usually includes licensed dental hygienists, dental assistants or denturists, etc.

Dependent(s)

Your eligible Dependent(s) are your spouse/partner, your children and your spouse/partner's children (other than foster children) who are residents of Canada and the United States.

Spouse/Partner

- your spouse or partner by virtue of a legal marriage, or
- your partner of either sex in a relationship of some permanence, if you are the natural or adoptive parents of a child, as defined in the Family Law Act, 1990 (Ontario), or
- your partner who cohabits with you in a conjugal or homosexual relationship continuously for a period of not less than 1 year, or
- your partner who is publicly maintained and represented as your spouse continuously for a period of not less than 1 year.

Only one person at a time can be covered as your Spouse/Partner.

Children age 21 and under

- unmarried and under age 21, who live with you in a normal parent/child relationship.
- unmarried child under age 21 for whom you are appointed legal guardian and lives with you in a normal parent/child relationship.

Children over age 21 but under age 25 (Student)

- unmarried child who is attending college or university as a full-time student is also considered an eligible Dependent until the age of 25 as long as the child is entirely dependent on you for financial support.

Children with a Handicap

If a child is handicapped before the age of 21, coverage will be continued after the age of 21 as long as:

- the child is incapable of financial self-support because of physical or mental disability, and
- the child depends on you for financial support and maintenance and remains unmarried.

In order to ensure there is no disruption in benefit coverage you must notify your Benefits Administrator within 31 days of the Dependent's 21st birthday.

Doctor

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

Eligibility Requirements

Conditions that must be satisfied in order to participate in the Plan, and obtain a benefit.

Employee

You are employed by the College on a full-time basis as a Support Staff employee in accordance with the terms of the Support Staff Collective Agreement.

Hospital

A hospital is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day.

Any legally operated institution in which a person establishes to the satisfaction of Sun Life that such confinement was for active treatment that would normally be found in a general hospital is considered a hospital for the purpose of this contract.

Facilities and services that are not covered

The Plan does not cover the facility nor the services provided in a nursing home, rest home, home for the aged, chronic care facility or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Palliative Care

Services for palliative care provided at a hospital, as defined under Regulation 964 under the Public Hospitals Act, R.S.O. 1990, c.P-40 are covered by the Extended Health Care Plan.

Services for palliative care provided at Casey House or any other hospice which is approved for hospital purposes pursuant to an Order-in-Council under the Public Hospitals Act are covered by the Extended Health Care Plan.

Illness

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.

Incurred Expense

You incur an expense on the date the service is received or the supplies are purchased or rented.

Reasonable and Customary Expenses

Standard medically approved treatments and procedures which are normally applied in the treatment of a particular illness or condition and are provided at costs equivalent to the normal charges for such treatment in the location where such treatment is provided.

Survivor(s)

Eligible Dependent(s) of an employee who becomes deceased while employed by the College provided the employee was participating in the group insurance benefits at the time of his or her death. Refer to Section 9 for further details.

Section 4 - When Coverage Begins

Employee (Mandatory Benefits)
Basic Life Insurance
AD & D
Extended Health Care (including Vision and Hearing Care)
Dental Care
Long Term Disability

Your coverage begins:

- the first day following the completion of the waiting periods provided you are 'actively at work full time' on the date your coverage becomes effective.
- in the event you are absent on that date, you will qualify on the day you return to 'active work full time'.

Employee (Optional Benefits)
Supplementary Life Insurance
Dependent Life Insurance
Supplementary Spousal Life Insurance

Your coverage begins:

- the first day following completion of the waiting period, if you have applied on or before completion of the waiting period.
- the date your request is received by the College, if it is received within 31 days of completion of the waiting period.
- the date of approval by Sun Life of evidence of insurability, if your written request is received later than 31 days after completion of the waiting period.

Actively at Work Provision

You are considered to be actively working if you are performing all the usual and customary duties of your job with the College for the scheduled number of hours for that day. This includes scheduled non-working days and paid vacation if you were actively working on the last scheduled working day. If for any reason, you stop being actively at work, you should contact the Benefits Administrator at your College to determine the status of your benefits.

In the event benefit improvements for Life Insurance and Long Term Disability are negotiated, you must be actively at work full time on the date the changes are effective in order to qualify for the improvements. If you are absent on that date, you will qualify on the date you return to active work full time. For the purpose of Long Term Disability, you must also be able to perform all the normal duties of your regular occupation.

Dependent(s)

Coverage for your Dependents begins on the latest of:

- the date you become eligible, if they are your Dependents on that date.
- the date they first become your Dependents after the effective date of your coverage, if your request for coverage is received by the College within 31 days, or
- on the date of approval by Sun Life if your request for coverage is received later than 31 days after they first become your Dependents.
- for a Dependent, other than a newborn child, who is hospitalized, coverage will begin when the Dependent is discharged from hospital.

Section 5 - Waiting Periods

New Employee

The waiting period for a new employee under your group contract is indicated on the following chart:

BENEFIT	WAITING PERIOD
Basic Life Insurance Accidental Death & Dismemberment Insurance Supplementary Life Insurance Dependent Life Insurance Supplementary Spousal Life Insurance Extended Health Care (includes Vision and Hearing Care)	On completion of one month of continuous full-time employment.
Dental Care	On completion of the probationary period.
Long Term Disability	On completion of the period from the date of full-time employment up to and including the last day of the third month of continuous full-time employment.

Section 6 - Enrolment

Enrolment Form

At the time you commence employment, the Benefits Administrator at your College will arrange to meet with you to review your Group Insurance Benefit entitlements.

You will be required to complete and sign a detailed enrolment form which collects the information necessary about yourself and your Dependent(s) (if applicable) in order for the College to administer the Group Insurance Benefit Program, and for Sun Life to adjudicate and process claims. It is imperative that you read this form, fully answer the questions, and return it to your Benefits Administrator promptly.

This enrolment form also contains information relating to the completion date of your waiting period and the effective date of your mandatory and optional benefits.

You will be enrolled in the mandatory and optional benefits following completion of the appropriate waiting periods.

Your Certificate Number

Your College will assign you a certificate number and is required to issue a personalized Certificate Card for you to retain in the event you need to produce proof that you have benefit coverage. This number will be a unique number and will contain a code to identify your employee group, your College and your file. This is necessary in order for you to be able to access your claims information from Sun Life.

Confidentiality

Your privacy is respected and the information collected is held between the Colleges and Sun Life in the strictest confidence and will not be divulged to any other party without your consent.

Updating your Records

To ensure that your benefit coverage is kept up-to-date, it is important that you report any of the following changes to your Benefits Administrator at the College:

- change of name.
- change of beneficiary.
- addition of a spouse/partner and/or dependent child.
- change in marital status.
- death of a spouse/partner and/or dependent child.

Section 7 - Changing Benefit Coverage

Changes affecting your coverage

Changes in employment and personal status may affect your benefit coverage. It is important for you to contact your Benefits Administrator to discuss your benefit coverage prior to the effective date of an employment status change or within 31 days following a personal status change.

Benefit coverage during leaves of absence, illness, etc.

There is provision in your group contract for you to continue benefit coverage when you are not actively at work, provided certain criteria are met. This means that if you are absent from work on an employer-approved personal leave of absence with pay, personal leave of absence without pay, maternity/parental leave, professional development leave, illness or disability, benefits can be continued.

If you are absent on a leave of absence without pay the maximum period of time you may continue to participate in the benefit plans is 24 consecutive months.

Personal status changes and Extended Health and Dental Care benefits

You may change your Extended Health, Vision, Hearing, and Dental Care coverage from single to family or vice-versa under the following special circumstances:

- if there is a change in your marital status.
- if you gain or lose a dependent.

To change your coverage, you must notify the Human Resources Department within 31 days of when the change takes place.

Please note that in the event of a marriage breakdown resulting in divorce your ex-spouse/partner is no longer eligible for benefit coverage.

To add or increase Life Insurance coverage

In the event you wish to add, or change the amount of your Optional Life Insurance, or obtain Life Insurance for a newly acquired Dependent, you may do so without a medical examination or other evidence of insurability provided you are actively at work and you apply for the Life Insurance coverage for you or your Dependent within 31 days of the following:

- the date you acquire a Dependent or an additional Dependent, or
- if you were covered for benefits under your spouse's group contract and coverage is terminated because of your spouse's death, marriage breakdown or termination of employment, the date such coverage terminates.

Proof of good health

To increase your Life Insurance or obtain Dependent Life Insurance at any time other than referenced above you will be required to submit proof of good health via a Health Questionnaire Form obtained from the College.

If coverage previously declined

In the event you have previously applied for and been declined for additional Life Insurance coverage, the 31 days provision referenced above is not applicable. You may continue to submit proof of good health to Sun Life annually. However, depending on your individual situation, you may never be eligible for this coverage.

Effective date of coverage

- if proof of good health is required, the change cannot take effect until Sun Life approves your application.
- if you are not actively working full-time when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active full-time 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 from hospital.

Section 8 - Termination of Coverage

When coverage ends

For Active Employees

As an employee, your coverage will end on the earliest of the following dates:

- the end of the month in which your employment terminates.
- the end of the month in which you retire, and have not elected retirement benefits.
- the date the group contract is no longer in force.
- the end of the period for which the premium is paid for your insurance.
- the date you die.
- for Long Term Disability (LTD), the date you attain age 64 and 6 months.
- for Supplemental Life, Dependent Life and Spousal Supplemental Life the end of the month in which you attain age 65.

For Dependent(s) of Active Employees

Your Dependent's coverage will end on the earliest of the following dates:

- the end of the month on which your insurance coverage ends.
- the date the group contract is no longer in force.
- the end of the period for which premiums have been paid for the Dependent coverage.
- the date the Dependent no longer meets the definition of an eligible Dependent.
- the date you die. Survivor Benefits may be elected by your Dependent for Extended Health Care (including Vision and Hearing Care) and Dental Care coverage.

Coverage after Retirement

Employees who retire may continue certain benefits. Please refer to the Retirement booklets for an explanation of the benefits available to retiring employees.

Section 9 - Survivor Benefits

Survivor Benefits
For Eligible Dependent(s) of Active Employees

Provided you are participating in the Extended Health Care, Vision and Hearing Care and Dental Care Plans when you die, coverage will continue until the earliest of the following dates:

- the last day of the sixth month following the month in which you die.
- the end of the period for which premiums have been paid.
- the date the benefit provision under which the Dependent is covered terminates.
- the date the group contract terminates.
- the date the survivor no longer qualifies under the definition of Dependent.
- the date the survivor cancels the coverage.
- the date the survivor dies.

Who pays the premium?

The College pays the full premium for the first six months for the Extended Health (including vision and hearing care) and Dental Care benefits. Thereafter, the survivor may elect to continue the benefits and is required to pay all premiums. The deceased employee must have been covered for the benefits immediately prior to his or her death.

The eligible survivor may elect to continue the benefits until the date the employee would have reached age 65.

The eligible survivor may then elect to continue the benefits under the Retirement program.

The eligible survivor will be requested to provide the following information in order to ensure claims are paid appropriately and delays in processing the payments are avoided.

- his/her date of birth.
- his/her Social Insurance Number.

Section 10 - Categories of Benefits

Mandatory Benefits

You must participate in the following benefits:

- Basic Life Insurance
- Accidental Death and Dismemberment Insurance
- Long Term Disability
- Extended Health Care (includes Vision and Hearing Care)
- Dental Care

Premiums

Benefit	% paid by College	% paid by Employee
Basic Life Insurance	100%	0%
Accidental Death and Dismemberment	100%	0%
Long Term Disability	75%	25%
Extended Health Care	100%	0%
Dental Care	100%	0%
Vision Care	75%	25%
Hearing Care	75%	25%

Optional Benefits

You may elect to participate in the following benefits:

- Supplementary Life Insurance
- Dependent Life Insurance
- Supplementary Spousal Life Insurance

Premiums

Benefit	% paid by College	% paid by Employee
Supplementary Life Insurance	60%	40%
Dependent Life Insurance	0%	100%
Supplementary Spousal Life Insurance	0%	100%

Premium Deductions

The premiums the College pays towards your Basic Life and Supplementary Life Insurance are taxable income to you.

In addition to the cost of the benefits, Ontario Retail Sales Tax is applied to the actual premium and must be paid by you and the College. The College Benefits Administrator will provide the premium deduction information to you at the time of enrolment.

Premiums are considered Taxable Benefits

The Canada Revenue Agency has determined that the premiums and associated Retail Sales Tax the College pays on your behalf towards Basic Life Insurance and Supplementary Life Insurance are to be considered a taxable benefit. This amount will be included as part of your income and reflected on your Income Tax Statement from the College each year.

Section 11 - Extended Health Care
(Medicare Supplement)

General description of the coverage

The **Extended Health Care Plan** pays for eligible services or supplies that are medically necessary for the treatment of an illness and supplements your provincial hospital and medical insurance plans. Any amount payable under the Extended Health Care Plan is subject to the coinsurance and the list of eligible expenses. The Ontario Health Insurance Act prohibits duplication of coverage of the provincial medical and hospital plans. To qualify for this coverage under this plan, you must be a Canadian resident and entitled to coverage under OHIP or a medicare plan equivalent to OHIP from another Canadian province, territory or federal government.

In some instances, where permitted by law, expenses covered under this Extended Health Care plan are integrated with certain provincial medicare programs such as the Ontario Assistive Devices Program (ADP) and the Ontario Drug Benefit Plan (ODB). Please refer to the end of Section 13 for a brief description of these programs.

Who is covered?

All full-time Support Staff employees who have completed the waiting period are covered by the Extended Health Care Plan which includes semi-private hospital accommodation. Current employees who have elected to remain in Plan II (excludes coverage for semi-private hospital accommodation) will be grandparented. All new employees are automatically enrolled in the Extended Health Care Plan I (includes semi-private coverage) on completion of the waiting period.

Waiting Period

One month of continuous full-time employment. The coverage begins on the day following the completion of your waiting period provided you are actively at work on that day. Otherwise the insurance becomes effective when you return to work.

Amount of Coverage

- 100% of eligible expenses for semi-private Hospital coverage in Canada (Plan I only).
- 100% of eligible expenses for Vision Care to a maximum of $300 in any Benefit Year for persons under 18 years of age, and any two Benefit Years for persons 18 years of age and older.
- 100% of eligible expenses for Hearing Care to a maximum of $3,000 in each 3 Year Benefit period.

Note: Since there are specific plan years, the details of which are

referred to later in this booklet, it is recommended that prior to making a purchase for vision and/or hearing care, you contact Sun Life to ensure that you are eligible to claim the purchase.

85% of eligible expenses for:

- emergency hospital confinement outside Canada for room and board and other emergency hospital services for treatment of an acute, unexpected condition, illness, disease or injury that arises outside Canada and requires immediate treatment (excluding any room and board charge above the Hospital's semi-private rate) (Plan I only).
- emergency hospital out-patient services provided outside Canada for treatment of an acute, unexpected condition, illness, disease or injury that arises outside Canada and requires immediate treatment (Plan I only).
- services, while not confined to a Hospital, of private duty registered nurses or registered trained attendants.
- prescription drugs.
- medical services.
- services of doctors and surgeons outside Canada for emergency health services, subject to the medical fee schedule of the person's Province of residence.
- accidental dental services.
- paramedical services (licensed physiotherapists, occupational therapists, audiologists, optometrists, ophthalmologists, speech therapists, psychologists, naturopaths, massage therapist, osteopaths, chiropractors, acupuncturist, chiropodists or podiatrists).

Payment after coverage ends

If your Extended Health Care Insurance terminates while you are totally disabled, treatment of the disabling condition will be covered, while your total disability continues, as if your insurance under the Plan had continued in force for an additional 6 months.

This benefit also applies to pregnancy provided your pregnancy commenced prior to the termination of your service with your employer.

A similar extension of benefits is available for a Dependent who is totally disabled when his or her insurance terminates.

Coverage under more than one plan

If you are covered for Extended Health Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. Please refer to the 'Submission of Claim' section of this booklet for instructions.

Hospital expenses in Canada
Reimbursement Amount

Plan I will cover 100% of the following costs:

- the difference between the cost of a ward and semi-private hospital accommodation when confined to a hospital in Canada (includes all provinces and territories in Canada).
- hospital out-patient services provided in Canada.

Hospital expenses outside Canada
Reimbursement Amount

Plan I will cover 85% of the emergency health services costs as described below while you are temporarily outside Canada. Because this is not travel insurance it is recommended that you purchase additional travel insurance.

- a semi-private hospital room (Plan I).
- other hospital services provided outside of Canada (Plan I).
- out-patient services in a hospital.
- the services of a doctor, up to the difference charged by a doctor and the amount equal to the medical fee schedule of the person's Province of residence.

Prescription Drugs and Vaccines

Please note that doctors occasionally prescribe drugs which may be readily available over the counter or vaccines that do not require a prescription by law. These drugs and/or vaccines are not covered by the Plan. Ask your pharmacist about the category of the drug you have been prescribed when you get your prescription filled. You may gain substantial savings by purchasing these drugs on an over-the-counter basis.

Reimbursement Amount

The Plan will cover 85% of the cost of the medicines and supplies listed below:

- drugs, serums, vaccines, (including hepatitis B vaccine, and influenza vaccines) which by law are only available with a prescription as long as they are prescribed by a doctor, a dentist or, in Ontario, a Registered Nurse in the Extended Class, and are obtained from a pharmacist.
- patent and proprietary medicines, when such drugs are considered treatment for chronic conditions, and such condition is documented by a doctor’s statement.
- diabetic supplies, including insulin, needles and syringes.
- ostomy supplies.
- contraceptives.

The Plan will not pay for the following, even when prescribed:

- over-the-counter medications, except as noted for chronic conditions in bullet 2 above.
- the cost of giving injections, serums and vaccines.
- medicines obtained directly from a doctor or dentist.
- treatments for weight loss, including drugs, proteins and food or

dietary supplements.
- cough medicines.
- baby food and formula.
- hair growth stimulants.
- products to help you quit smoking.
- minerals, proteins and vitamins.

Medical services
Reimbursement Amount

The Plan will cover 85% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed dentist do not require a doctor's order).

Nursing

- services, while not confined to a Hospital, of private duty registered nurses or registered trained attendants, for a period commensurate with the nature and gravity of the illness. The services must be for nursing care, and not for custodial care.

  The private duty registered nurse, or registered trained attendant must be a registered nurse, or registered trained attendant who is licensed, certified or registered in the province where you live and who does not normally live with you.

Ambulance

- OHIP covers the cost of licensed ambulance services, where medically necessary, for local transportation of the person to and from the nearest hospital qualified to provide the required care.

  In the event that an unexpected condition occurs (emergency situation) such as illness, disease or injury which requires immediate assistance, the use of a licensed air ambulance for transportation of the person to the nearest hospital qualified to render the emergency medical services, the expense is covered by OHIP in the province of Ontario. The Extended Health Care plan will pay a maximum of what would have been payable for a local land ambulance trip.

  You are responsible to pay a co-payment (subject to change) for these services. The Extended Health Care plan will reimburse you for 85% of the co-payment amount.

Accidental Dental

- dental services for the repair or alleviation of damages to natural teeth sustained in an accident occurring while you or your Dependent(s) are insured under this provision. The services include braces and splints. These services must be received within 6 months after the accident. You will not be covered for more than the fee stated in the Dental Association Fee Guide for a general practitioner in the Province of Ontario. The fee guide must be the current guide at the time that treatment is received.

Note*:* It will be necessary for you to provide a separate detailed account of the cause of the injury to Sun Life along with the Extended Health claim form.

Medical Supplies and Equipment

- iron lungs or other durable equipment rented, that is for temporary therapeutic use.
- casts, splints, trusses, braces and crutches.
- breast prostheses and surgical bras, required as a result of surgery, up to a maximum of $600 per person in any Calendar Year.
- artificial limbs and eyes, including repairs and replacements when medically necessary. Coverage may be co-ordinated with the Assistive Devices Program administered by the Province. Further information is provided at the end of this section.
- oxygen and its administration.

Orthopaedic Shoes

- orthopaedic shoes, up to a maximum of 3 pairs for persons under 8 years of age, 2 pairs for persons 8 years of age or over but under 18 years of age and one pair for persons 18 years of age and over, in a Calendar Year.

In some circumstances you may wish to purchase orthotics in place of orthopaedic shoes, professionally prescribed that may be less costly. Prior to making your purchase it is recommended that you obtain confirmation that the claim will be eligible for payment. This can be done by forwarding the information given to you by the service provider directly to the claims department at Sun Life.

Paramedical services

The Plan will cover 85% of the costs, up to a combined maximum of $1,500 per person in a Calendar Year for all eligible expenses listed below; this includes the difference between what OHIP allows for podiatrists and your actual charge:

paramedical services must be deemed by the profession's licensing/regulatory board to be within the scope of that profession. A service deemed to not be within the scope of the profession will not be covered.

Doctor's order not required:
osteopath*, chiropractor*, chiropodist*, podiatrist*, naturopath, massage therapist, speech therapist, physiotherapist, audiologist, optometrist/ophthalmologist, occupational therapist, psychologist and acupuncturist.
*includes one x-ray examination per specialty each Calendar Year

What is not covered

The Plan will not pay for the costs of:

- services or supplies not included in the list of eligible expenses.
- equipment that is considered ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers and equipment used to treat seasonal affective disorders).
- services or supplies payable in whole or in part under the provisions of the Medicare plan in your province of residence.
- hospital services or supplies to the extent they are covered under the Hospital Plan which are paid for in whole or in part under the provisions of the Medicare plan whether or not you or your Dependent(s) are enrolled under the provincial plan.
- services or supplies for which the person is eligible for payment under any group medical, surgical or hospital plan.
- any services or supplies over the reasonable and customary charges in the locality where they are provided.

The Plan 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 a civil commotion.
- any work for which you were compensated that was not done for the College who is providing this Plan.
- the Plan will also not pay benefits when compensation is available under the Workplace Safety and Insurance Act, Criminal Injuries Compensation Act or similar legislation.

Section 12 - Vision Care

Vision Care

The Plan will cover the cost of contact lenses, laser eye correction surgery or eyeglasses-lenses and frames including tinting, sunglasses, safety glasses and their replacement, as long as they are prescribed in writing by an ophthalmologist or a licensed optometrist and are obtained from an ophthalmologist, licensed optometrist or qualified optician.

Laser eye surgery, if performed by an ophthalmologist may be co-ordinated with available coverage under paramedical services.

The Plan will cover 100% of these costs up to a maximum of $300 in any Benefit Year for persons under 18 years of age, with the Benefit Year commencing September 1 and a two Benefit Years period for persons 18 years of age and older, with the benefit period commencing September 1 of even numbered years. Maximums will renew annually for persons under 18 years of age and every 2 years for all other persons.

The Plan will not pay for glasses of any kind purchased over the counter or examinations by eye care professionals.

PVS - Preferred Vision Services Inc.

Sun Life offers a Preferred Vision Care program. You can achieve a savings of up to 20% on all frames, prescription lenses and lens add-ons at registered PVS locations. You will be required to present your PVS card at the time of purchase. PVS cards can be obtained from your College Benefits Administrator.

Section 13 - Hearing Care

Hearing Care

The Plan will cover the cost of hearing aids, including maintenance and repairs, prescribed in writing by an Ear, Nose and Throat (E.N.T.) specialist, Otolaryngologist, Medical Doctor (M.D.) or an Audiologist, up to a maximum of $3,000 per person for the current benefit period ending August 31, 2006. The maximum is then $3,000 every 3 consecutive years thereafter.

Coverage may be co-ordinated with the Assistive Devices Program administered by the Province.

Coverage under more than one plan

If you are covered for Vision and Hearing Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. Please refer to the 'Submission of Claims' section of this booklet for instructions.

Government Plans

Details of current coverage under the government medicare plans can be found on the website of the Ontario Ministry of Health and Long Term Care at www.health.gov.on.ca. The following provides a brief description of some of the services that are integrated with your Extended Health Care coverage.

Assistive Devices Program (ADP): This program is operated by the Ontario Ministry of Health. It assists Ontatio residents covered by the Ontario Health Insurance Plan who have a long term physical disability (ask your doctor for details). The program covers a number of items such as hearing aids, orthotic devices, ostomy supplies, prosthetic devices (such as breast prostheses), etc. As coverage can change from time to time, please refer to the Ontario Ministry of Health and Long Term Care website for details.

Home Oxygen Program (HOP): This program covers oxygen and oxygen delivery equipment such as concentrators, liquid systems, masks, tubing, etc. Contact the Operational Support Branch of the Ontario Ministry of Health and Long Term Care for details.

Ontario Drug Benefit Plan (ODB): You and/or your spouse are eligible for the prescription drug benefit on the first day of the month following the attainment of age 65.

Section 14 - Out-of-Province Coverage and Your Extended Health Care Plan

About the coverage

Each Province or Territory has its own hospital and medical services plan and provincial health insurance act. These provincial programs have to meet minimum standards of service and administration set out by the federal government under the Canada Health Act.

Most provinces, through reciprocal agreements, provide coverage to other non-resident Canadians at the rates prevailing in their home province for standard medical procedures and hospital care. In most instances, reimbursement for emergency services rendered out-of-province are billed directly to the home province. There may be a few instances where you are required to pay the bill and obtain reimbursement from your home provincial plan.

You will be reimbursed for any eligible expenses or services at the same amount you would have received if the item or services were purchased or rendered in Ontario.

If a particular service is covered in part by OHIP, Sun Life is generally not permitted to cover the balance when the expenses are incurred in Canada.

Moving Out of Province

If you move from one province to another province or territory it is important that you register for the provincial medicare plan in your new province as soon as possible (90 days or less) so that you do not jeopardize your Group Insurance benefits coverage.

Section 15 - Out-Of-Canada Coverage and Your Extended Health Care Plan

About the coverage

Your Extended Health Care Plan covers only emergency health services while you are temporarily outside of Canada as long as you have maintained your benefit coverage.

Emergency Health Services

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

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

This Plan is not intended as full travel insurance. It covers the cost of semi-private hospital room accommodations, out-patient services in a hospital, the services of a doctor, up to the difference charged by a doctor and the amount equal to the medical fee schedule of the person's province of residence for emergency health services only.

The Plan does not cover the cost of expenses which would generally be designed solely for travel purposes such as repatriation insurance, return of your rented vehicle and other non-medical expenses, etc.

If you are leaving Canada you should review your Extended Health Care Plan and your personal needs in order to determine your requirements for an Out-of-Canada Plan.

Eligibility for coverage

The Plan is not intended to satisfy the needs of someone who is permanently residing outside of Canada (in fact, a Dependent who is not a resident of either Canada or the U.S. is not eligible for coverage). Canadian residency status entitles you to provincial Medicare.

Special Note:
If you lose your Canadian residency status you will not be able to participate in the Group Insurance Benefits Program.

How much is paid?

Regardless of the currency quoted on the bill, benefits are payable in Canadian dollars with the exchange rate at the time of claim

adjudication being taken into account.

What is covered?

If a particular service is covered in part by OHIP, the Extended Health Care Plan is generally not permitted to cover the balance when the expenses are incurred in the home province. This restriction does not apply to expenses which are incurred out-of-Canada and the Extended Health Care Plan does cover many of these unpaid balances.

Hospital:

Out-of-Canada hospital bills are considered eligible only if you have Extended Health Care Plan I coverage. The amount payable is 85% of the difference between:

- the amount billed exclusive of any charge for room and board above the semi-private level and any charge for non-essentials such as television rentals and gourmet meals, and
- the amount payable by OHIP.

Example:- Assumptions:

- 4 day hospital stay at $1,200 U.S. per day
- $45 U.S. per day semi-private to private differential
- Exchange rate is 1.379
- All figures in Canadian dollars

■ Full Bill (including private room)	$6,619.20
■ Less semi to private differential	-248.22
■ Net Bill	6,370.98
■ OHIP payment (4 x $400)	-1,600.00
■ Balance	4,770.98
■ Sun Life Payment (85%)	4,055.33
■ Balance	715.65
■ Semi-private to private room differential	+248.22
■ You would be required to pay	$963.87 or $240.97 per day

The following is an example of what the Plan will pay or you may be required to pay if you do not have semi-private hospital accommodation.

■ Full Bill (including private room)	$6,619.20
■ OHIP payment (4 x $400)	-1,600.00
■ Balance	5,019.20
■ Sun Life pays (Nil)	---------
■ You would be required to pay	5,019.20 or $1,254.80 per day

Doctors:

Doctors services for emergency health services when rendered outside

of Canada are covered under Plan I and II with the amount payable equalling 85% of the difference between the bill and the OHIP allowance, provided that difference does not exceed the prevailing Ontario Medical Association (OMA) Schedule of Fees for the service in question. Currently, the OHIP schedule is approximately 70% of the OMA Schedule.

Example 1

Appendectomy - Miami	
U.C.R. Charge*	(US) $1,810.99
Charge at 1.379	(Canadian) 2,497.35
OHIP Payment	233.50
Amount Outstanding	2,263.85
OMA Fee Schedule	377.84
Sun Life Payment (85%)	321.16
You would be required to pay	(Canadian) $1,942.69

Example 2

Endoscopy - Miami	
U.C.R. Charge*	(US) $1,050.39
Charge at 1.379	(Canadian) 1,448.48
OHIP Payment	53.10
Amount Outstanding	$1,395.38
OMA Fee Schedule	85.93
Sun Life Payment (85%)	73.04
You would be required to pay	(Canadian) $1,322.34

****U.C.R. Charge*** Usual, customary, reasonable charge.

Ambulances: OHIP covers the cost of licensed ambulance services, where medically necessary, for local transportation of the person to and from the nearest hospital qualified to provide the required care.

You are responsible to pay a co-payment which is currently $45 (subject to change) for these services. The Extended Health Care plan will reimburse you for 85% of the co-payment amount.

The cost of airfare home from Out-of-Province is not defined as an eligible expense. This is one of the reasons why you should obtain advice and make a decision about purchasing medical coverage over and above that provided by the Colleges Extended Health Care plan when travelling out of Canada.

Other expenses: Other than those noted above, none of the eligible expenses are subject to geographical restrictions. Consequently, if an item would have been covered if purchased or rendered at home, it is covered (85%) if incurred out of the country. All such expenses are subject to any

applicable internal limits such as those which would apply to chiropractors.

Section 16 - Dental Care

General description of the coverage

Amount of Coverage

- 100% of eligible expenses for preventative dental procedures.
- 100% of eligible expenses for restorative and surgical procedures.
- 100% of eligible expenses for prosthodontic procedures.
- 50% of eligible expenses for inlays, onlays, crowns, repairs of crowns, repair of bridges, construction and insertion of bridges.
- 50% of eligible expenses for orthodontic procedures.

What are the maximums?

	Insured Percentage	Maximum
Types A, B, C Eligible Expenses: Basic Services, including Dentures	100%	$2,000 Types A, B and C combined (per calendar year)
Type E Eligible Expenses: Crowns and Bridges	50%	$2,000 (per calendar year)
Type D Eligible Expenses: Orthodontics	50%	$2,500 (Lifetime)

What fees are covered?

The fees stated in the Ontario Dental Association Fee Guide for general practitioners which was current one year prior to the date the eligible expenses were incurred, regardless of where the treatment is received.

Temporary Dental Services

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.

Preventive Dental Procedures ***(Type A)***

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.

How much will the Plan pay?

The Plan will pay 100% of the eligible expenses for the following procedures. The specific Ontario Dental Association procedure codes shown below are based on the 1997 Ontario Dental Association suggested fee guide for general practitioners. These codes are referenced on the Dental Claim form and are subject to change from year to year.

Oral examinations

Initial examination limited to one during any 24 month period.

1 recall examination maximum of 2 examinations per Calendar Year, separated by an interval of at least 5 months.

Emergency or specific examinations .

Preventive recall packages.

X-rays

1 complete series of x-rays or 1 panorex limited to one during any 24 month period.

1 set of bitewing x-rays limited to one during any 6 month period.

X-rays to diagnose a symptom or examine progress of a particular course of treatment.

Other services

Required consultations between patient and dentist, excluding those for orthodontic purposes.

Fillings - amalgam, silicate, composite, acrylic or equivalent.

Cleaning and topical fluoride treatment limited to one during any 6 month period, up to a maximum of 2 per Calendar Year.

Protective athletic appliance (mouthguards).

Scaling.

Other preventive services.

Diagnostic tests and laboratory examinations, excluding x-rays, study models or similar records prepared for orthodontic procedures..

Provision of space maintainers for missing primary teeth.

Restorative Dental and Surgical Procedures
(Type B)
How much will the Plan pay?

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

The Plan will pay 100% of the eligible expenses. The specific Ontario Dental Association procedure codes shown below are referenced on the Dental Claim form and subject to change from year to year in accordance with the Dental Association.

Required consultations with another dentist.

Retentive pins.

Prefabricated, full coverage restorations.

Caries, trauma and pain control.

Professional visits.

Extraction of teeth

Removal of teeth.

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.

Oral surgery

Surgery and related anaesthesia, other than implants and transplants, and repositioning of the jaw.

Therapeutic intra-muscular or intravenous drug injection.

Prosthodontic Dental Procedures
(Type C)
How much will the Plan pay?

Your dental benefits include procedures used to treat major dental problems. Some examples are crowns, dentures or bridges.

The Plan will pay 100% of prosthodontic services (dentures) including repairs, relining and rebasing of dentures. The specific Ontario Dental Association procedure codes shown below are referenced on the Dental Claim form and subject to change from year to year in accordance with the Dental Association.

Laboratory Fees

Certain procedures will usually involve the cost of a commercial laboratory and when appropriate, a reasonable and customary laboratory fee will be included in your benefits, payable at the same coinsurance as the dentist's charge associated with it and subject to the same overall maximums. Please note that predetermination cannot take laboratory fees into account but the appropriate payment will be included at the time of claim.

Dentures

Complete maxillary and/or mandibular dentures - once every 3 years per arch.

Removable partial dentures - once every 3 years.

Denture adjustments.

Repair of Dentures

Repair of dentures.

Rebase or reline

Rebase or reline of an existing partial or complete denture.

Bridge Repairs

Bridge repairs are covered at 50% of the amount payable under the appropriate fee guide. The remainder is paid by you.

How much will the Plan pay for Crowns and Bridges?

Other major dental services, including new crowns and bridges are covered at 50% of the amount payable under the appropriate fee guide. The remainder is paid by you. Details of the services follow including restrictions and limitations.

Additional Prosthodontics

Inlays.

Onlays.

Pins in inlays, onlays and crowns.

Post and core.

Crowns and repairs to crowns.

[Special Provisions for Implants: If a claim is made for an implant, **the implant itself and related surgery are not an eligible expense** under the Plan; however, the plan may reimburse you for up to the level of service that is applicable under the alternate benefit clause.
The Plan will pay based on the least expensive alternate service as follows:

- If a crown is "the least expensive alternate service", the Plan will reimburse the allowable fee for a standard crown.
- If a denture is "the least expensive alternate service", the Plan will reimburse up to the allowable fee for a denture, either partial or full.
- If a bridge is "the least expensive alternate service", the Plan will reimburse up to the allowable fee for a bridge.

Please refer to the section "What is not covered" for more information about the alternate benefit clause. A pre-determination will identify what portion of the cost, if any, will be reimbursed.**]**

Repair of bridges.

Prosthodontic services - construction and insertion of bridges or standard dentures - once every 3 years.

Charges for a replacement bridge or replacement standard dentures are not considered an eligible expense during the 3 year period following the construction or insertion of a previous bridge or standard denture unless:

- 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.

Orthodontic Procedures
(Type D)
How much will the Plan pay?

Your dental benefits include procedures used to treat misaligned or crooked teeth subject to a lifetime maximum of $2,500 per person.

The Plan will pay 50% of the amount payable under the appropriate fee guide. The remainder is paid by you.

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

The following orthodontic procedures are covered:

- Diagnostic services - orthodontic cast.
- Observation and adjustment.
- Repairs.
- Alterations.
- Re-cementations.
- Separation.
- Fixed - bilateral/unilateral or removable orthodontic appliances.
- Appliances to control oral habits.
- Myofunctional therapy.
- Retention appliances.

Predetermination
Recommended where expenses will exceed $300

To ensure that you and your Dentist are aware of the expenses that will be paid by the Plan, it is strongly recommended that you send a predetermination form to Sun Life, before the work is done, for any major treatment or any procedure.

How do I file a predetermination?

This can be done by your Dentist directly via electronic submission or if necessary:

- you can obtain a claim form from your Human Resources Department.
- ask your Dentist to complete the appropriate sections of the form.
- you complete your sections of the form, sign it and forward it to Sun Life.

Sun Life will advise you, taking into account possible alternate procedures or course of treatment based on accepted dental practice, how much of the planned treatment is covered by the Plan and how much of the cost you will be responsible for before the work is done.

The only circumstance in which benefits will be considered for an ineligible procedure is when your Dentist advises, in writing, that it is both less expensive and better for you than an eligible procedure which could be done.

Coverage under more than one plan

If you are covered for Dental Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. These standards determine where you should send a claim first. Please refer to the 'Submissions of Claims' section of this booklet for instructions.

What is not covered

The Plan will not pay for:

- services or supplies payable in whole or in part under any legislation, except for user fees and extra billing if the legislation allows the user fees and extra billing.
- services or supplies that are not usually provided to treat a dental problem, including experimental treatments.
- any portion of the charge over the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental services when such alternate service or material is customarily provided.
- 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.

Dental expenses resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- participation in a criminal offence.
- any cause for which compensation is available under the Workplace Safety and Insurance Act, Criminal Injuries Compensation Act or similar legislation.

Payments after coverage ends

If your coverage ends, coverage is still available for procedures to repair natural teeth damaged by an accidental blow if:

- the accident occurred while the person was still covered, and
- the procedure is performed within 6 months after the date of the accident.

Expenses Outside of Province/Canada

Expenses incurred for emergency dental care outside of Province/Canada will qualify as eligible expenses to the extent that they represent the usual, customary and reasonable charges for dental care in the locality where the dental care is performed, provided an expense for such dental care would qualify as an eligible expense in the Province of Ontario.

For expenses incurred for dental care performed outside Canada on other than an emergency basis, the benefit provided under this contract will be the usual, customary and reasonable charges for dental care in the locality where the dental care is performed but not exceeding the level of eligible expenses for the Province of Ontario.

Section 17 - Short Term Disability Plan (STD)

General description of the coverage

The Colleges have full legal, financial and administrative responsibility for this benefit. Questions or inquiries in regard to this benefit must be directed to your College Benefits Administrator.

If you are hired as a full-time employee on or after September 1, 2005, you are eligible for benefits under the Short Term Disability Plan (STD) from the first day of work with the College.

The STD will provide benefits for the first 130 working days you are absent due to an illness or disability in a "plan year".

The first ten (10) working days in the "plan year" will be paid at 100% of your regular base earnings with the remainder of the 130 working days paid at 75% of your regular base earnings. Employees in their first year of employment will have their ten (10) days entitlement pro-rated in proportion to the amount of the year that they work.

The ‘plan year” begins on September 1 of each year.

If you recover from one absence due to illness or disability but are again absent due to illness or disability during the plan year, STD benefits will recommence from the point at which they were discontinued.

Full STD benefits are normally reinstated on the first working day of each new plan year, provided you are actively at work full-time on that day and you are not absent again for the same or related cause for which benefits were paid under the previous year's entitlement. If you are absent on that day, the following procedures will apply:

(1) (a) Full STD benefits will be reinstated following one month of return to your regular hours of work provided you are not again absent due to the same illness or disability.

(b) If you are absent due to the same illness or disability, you may only use the balance of benefits from the previous plan year.

(2) If you return to your regular hours of work and are absent due to illness or disability during the first 30 calendar days following your return due to a different illness or disability, full benefits will be reinstated at the end of that period. However, this absence may be covered by any balance of credits from the previous plan year, as indicated below.

Short Term Disability payments will be reduced by other disability payments being received such as from the Canada Pension Plan or the Workplace Safety Insurance Board.

ACCUMULATION OF UNUSED STD DAYS

Any of the ten (10) days paid at 100% that are unused at the end of the plan year will be carried forward to the next plan year to be used in future years. Unused days can only be carried forward to a maximum accumulation of 120 working days and may only be used for the STD benefit.

This extends the number of days you receive 100% of your regular base earnings from ten (10) working days by the number of unused STD days that have been "banked" to a maximum of 130 working days. Once these days have been used, the remainder of the 130 working days allowed in a plan year will be paid at 75% of your regular base earnings.

Upon retirement, layoff or termination of employment, unused days banked in your name shall be cancelled and shall be of no effect.

After you have used the 130 working days of STD benefits, which are available in one plan year (together with any extensions available, if any, pursuant to the "Accumulative Sick Leave Credits" specified below), benefits may be provided under the Long Term Disability Insurance Plan, underwritten by Sun Life Assurance Company of Canada.

The full cost of all Short Term Disability benefits is paid by the College.

ACCUMULATIVE SICK LEAVE CREDITS PRIOR TO SEPTEMBER 1, 1973 AND NOT APPLICABLE TO SUPPORT STAFF HIRED AFTER SEPTEMBER 1, 1973

Your accumulative sick leave credits prior to September 1, 1973 will

be maintained. However, there will be no further accruals or transfer-in of accumulative sick leave after September 1, 1973. Existing accruals will be frozen and used to supplement the STD Plan. One-quarter of a credit from the accrual will be used to supplement each day under the STD plan from 75% to 100% of earnings.

If, at the end of the 130 working days STD period there are any unused credits in the sick leave accrual, you will continue to draw sick leave on a per day basis at 100% of earnings level until these credits are exhausted. The commencement of Long Term Disability benefits, will be deferred until all sick leave entitlements have been paid.

Any vesting provisions that may have been established or agreed to by the College applicable to past sick leave credits recognized at the commencement of employment will continue to apply to any such unused credits remaining in the accrual, in accordance with the conditions and provisions established by the College at the commencement of employment. The vesting provisions established by the College applicable to current sick leave credits accrued while employed by the College will apply to any such unused credit remaining in the accrual. The dollar amount of any cash benefit to be paid in accordance with the relevant conditions established by the College will be based on salary at December 31, 1977 or in the case of some former public servants retiring prior to December 31, 1977, the date of retirement. The gratuity is calculated in accordance with the following formula:

$$\frac{\text{No. of days of credit}}{2} \times \frac{\text{Salary at December 31, 1977}}{261}$$

The cash benefit payable following an employee's death will be determined in the same manner as for a retirement.

Vesting provisions distinguish between sick leave credits earned before and after joining the College, and therefore the accrual will be determined on a first-in first-out basis. (Viz: The transferred credits are used before College credits are drawn upon).

Since these benefits relate to the old cumulative Sick Leave Plan, they will be paid by the College.

Section 18 - Long Term Disability Income Plan (LTD)

General description of the coverage

As a full-time Support employee you have Long-Term Disability coverage, which provides a benefit to you if you become 'totally disabled' for an amount equal to 66 2/3% of your regular earnings. Employees receiving disability payments under the Plan up to September 1, 1974, shall continue to receive benefits under the original Plan providing for benefits of sixty per cent (60%) of regular earnings so long as such disability continues and subject to the provisions of the original Plan.

If you become totally disabled while insured, Sun Life will pay, subject to Limitations and Exclusions, a Long Term Disability Benefit for each month you remain totally disabled after completion of the elimination period until you cease to be totally disabled or the last day of the month in which you attain age 65. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you are under the regular care of a doctor.

If the group contract is cancelled for any reason while you are receiving the Long Term Disability Benefit, payments will continue in accordance with the terms of the group contract.

Total Disability

You are considered totally disabled if, because of bodily injury, sickness or disease:

- you can perform none of the duties relating to your regular work during the elimination period and subsequently for a period up to but not exceeding 24 months, and
- afterwards, you will be considered totally disabled if you are wholly and continuously prevented from engaging in any occupation or employment for wage or profit for which you are reasonably qualified by education, training or experience.

Elimination period

To be eligible for Long Term Disability Benefits, you must have completed the waiting period for benefit coverage and have been 'totally disabled' for the elimination period specified in your plan.

The elimination period is the amount of time during which you must have been unable to work due to your incapacity. This is normally the period of time when you would have received Short Term Disability or Cumulative Sick Leave Credit payments from the College.

When disability payments begin

Your Long Term Disability payments begin after you have completed the elimination period. The elimination period is the period commencing when you became totally disabled and ending on the later of:

- the completion of 130 working days (including statutory and college holidays) of absence due to illness in the past 12 months, or
- the expiration of Short Term Disability and Sick Leave Credits.

Payment of Long Term Disability benefits is not automatic. You must submit an LTD claim. In addition, you may also be eligible for Canada Pension Plan disability benefits and you are advised to contact the nearest Income Security Program office, Human Resources Development Canada (HRDC).

Eligibility for coverage

The waiting period is the period from the date of your full-time employment up to and including the last day of the third month of employment. Coverage begins on the day following the completion of the waiting period, provided you are actively at work on that day. Otherwise the insurance becomes effective when you return to work.

Coverage ends

Your coverage will end on the earliest of the following dates:

- the end of the month in which your employment terminates.
- the date you attain age 64 and 6 months.
- the end of the period for which the premium is paid for your insurance.
- the date your group contract is no longer in force.
- the date you die.

If you become totally disabled during an approved leave and have elected to continue your coverage during the leave period you will be eligible for benefit payments following your scheduled return to full-time work with your College. You must have been totally disabled for the elimination period and still be totally disabled on the date you are scheduled to return to full-time work with your College.

Ceasing to be actively at work does not, by itself, mean that you are totally disabled.

Proof of disability

Once the claim is approved, proof of your continuing disability will be required from time to time depending on the medical evidence

previously supplied by your doctor. Sun Life will send the appropriate documents when this information is required. The information requested will be used to determine your eligibility for the continuance of benefits and should be obtained and returned to Sun Life promptly (usually within 90 days) in order to avoid unnecessary interruptions or delays in your benefit payments.

In the event you no longer qualify as totally disabled, Sun Life will notify the College Benefits Administrator who is responsible for notifying you.

Medical examination

At the time your application is made for Long Term Disability benefits, medical information must be included. In the event that Sun Life is unable to render a decision on the claim based on the medical information provided, Sun Life may arrange for you to have an Independent Medical Examination (IME), at their expense.

Your cooperation in complying with Sun Life's request for an IME is very important because without the appropriate medical information Sun Life cannot approve the claim and benefits cannot be paid. An IME may also be required as proof of continuing disability.

How will my benefits be determined?

You will receive 66 2/3% of your Monthly Basic Earnings reduced by income from all other sources.

Monthly Basic Earnings

Monthly Basic Earnings are your regular earnings on the date of commencement of your elimination period.

Income Tax

The amount payable by Sun Life is subject to income tax. However, unless specifically requested, it is not deducted at source.

Income from other sources

The following is 'Income From Other Sources' and will be subtracted from your LTD benefits:

- any continuation of salary from any employer in respect of employment prior to the date of commencement of the elimination period.
- any indemnity provided under any group insurance or group pre-payment plan.
- any amount of income provided under any retirement or pension plan of the Employer.
- any indemnity from any government operated or sponsored plan such as the Workplace Safety and Insurance Act, Canada Pension Plan and Quebec Pension Plan.
- any amount of income provided for you by reason of your disability under the legislation of any government or emanation thereof.

Please note:
you have a responsibility to ensure that you are receiving the proper benefit payment and that any offsets have been applied appropriately.

Not included in 'Income from Other Sources' are the following:

- any increase in income arising from the Quebec Pension Plan or the Canada Pension Plan because of an upward adjustment in the cost of living index (occurring either during the elimination period or while you are receiving a Monthly Indemnity Benefit).
- payments from Employment Insurance.
- payments from any Personal Life or Personal Disability policies.
- any amount of income provided for your Dependent(s) by reason of your disability under the legislation of any government or emanation thereof.

How will I receive my benefits?

The Long Term Disability Plan pays in advance. This means that your first benefit payment is due the first day after completion of the elimination period indicated on the application form submitted by the College. Subsequent payments are made on the first day of each month that you continue to qualify for benefits under the terms of the group contract.

You will be given the option of receiving your benefit payments by either cheque or electronic funds transfer directly into your bank account.

To ensure the accuracy of your disability benefit payments, you must advise your College Benefits Administrator immediately if:

- your medical condition changes.

- you begin to receive any other income (i.e., Canada Pension Disability Benefits, or you return to work, either full-time or part-time).

Your College Benefits Administrator is also responsible for informing Sun Life if you return to work.

Rehabilitation Program

The College has the obligation under the Human Rights Code to provide 'reasonable accommodation' for disabled employees. This may involve modifications to the job or your workplace. If there is potential for rehabilitation, you will be contacted by either your College Benefits Administrator or a Sun Life Counsellor.

Where there is the possibility of rehabilitation in order to return to work, you, your physician, the College or Sun Life may initiate the process.

Successful rehabilitation is a team effort and includes participation from the College, your Local Union representative, your attending doctor, Sun Life and you.

Rehabilitation Benefits

During your rehabilitation program, you may receive your Long Term Disability payments plus income from other sources, however, your Long Term Disability benefits will be offset by 50% of your rehabilitative earnings.

If, during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation, (less provincial and federal income taxes), your Long Term Disability payments will be reduced by the excess.

Recurrence of disability

If you have been receiving Long Term Disability payments and recover, but the same (or related) total disability recurs, you need not complete another elimination period unless you have been back at work on full-time for at least 6 months.

If you have a chronic disease or illness and suffer a relapse after the end of the period referred to above, Sun Life may, at its sole discretion, accept a subsequent claim as a continuation of the previous one at the same level of benefits and without applying a new elimination period.

Any such acceptance will be based on a consideration by Sun Life of the circumstances involved and will only be done if the group contract is in force at the time a request for such consideration is made. The benefits you receive will be based on the same benefit level as on the

original date of total disability.

How will my Life Insurance, Extended Health Care and Dental be affected?

Your Life Insurance, Extended Health Care and Dental Care remain in force during the time you receive Long Term Disability benefits provided that you were subscribing to such benefits on the date your Long Term Disability payments commenced.

Who pays the premiums?

The College shall pay one hundred per cent (100%) of the premiums payable for Extended Health Care, Vision Care, Hearing Care and Dental Care on your behalf if you are receiving Long Term Disability payments, provided you were enrolled in the benefits on the date your Long Term Disability payments began. No premiums are required for your Life Insurance coverage.

Waiver of LTD Premiums

No contributions for Long Term Disability will be required during any period you are receiving monthly benefits.

Your responsibilities

During your total disability, you are expected to make reasonable efforts to:

- keep the College and Sun Life informed about the status of your disability on a regular basis.
- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your College.
- return to your own occupation during the first 24 months that benefits are payable.
- obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 24 months that benefits are payable.
- try to obtain work in another occupation after the first 24 months that benefits are payable.
- obtain benefits that may be available from other sources.

When payments end

Your Long Term Disability payments end on the earliest of the following dates:

- the date you are no longer disabled.
- the last day of the month in which you reach age 65.
- the last day of the month in which you retire.
- the last day of the month in which you die.

Return to Work

Where you are eligible to receive Long Term Disability benefits and you are medically capable of returning to your former position within 24 months of being eligible to receive benefits, you shall be assigned, within a reasonable period of time, to:

- your former position
- a comparable classification in the same payband to your former

position provided you are capable of performing the job and such a position exists.

When you work less than the normal hours of work assigned to the position to which you have returned, your salary, Short Term Disability payments (if entitled) and vacation pay shall be pro-rated accordingly.

You shall not be required to work within 24 months of being eligible to receive Long Term Disability benefits unless you are medically capable of performing the duties of your former position.

Research has indicated that the most successful outcome of a return-to-work program is achieved when the rehabilitation program is engaged as soon as possible after commencement of disability.

If you have any questions pertaining to return to work, please feel free to contact your College Benefits Administrator, Local Union Representative or Sun Life.

Non-Payment of Long Term Disability

Limitations

In accordance with the group contract, Sun Life will not pay Long Term Disability benefits for any period that:

- you are not under the regular care of a doctor.
- a period during which you engage in any employment or occupation for wage or profit (other than in a Rehabilitation Program) except as approved by Sun Life.
- you are not participating in an approved rehabilitation program, if required by Sun Life.

Exclusions

Payment will not be made for a Total Disability which is due to or results from:

- participation in a riot, rebellion or, insurrection.
- war, declared or undeclared, or active duty in any armed service during a time of war.
- intentionally self-inflicted injuries, while sane or insane, by firearm or otherwise.
- commission or attempted commission of a criminal offence by you.

Recovering damages from a Third Party

This provision applies to every employee who claims Long Term Disability benefits under this group contract.

What are the Third Party Liability Provisions

If you have a cause of action against a Third Party for income lost as a result of your disability, the LTD benefit will be payable as specified in the group contract.

However, prior to the commencement of payments, you will be required to complete a form agreeing to reimburse Sun Life. The amount to be reimbursed will not exceed the amount of benefits paid by Sun Life.

If you recover money, you must pay Sun Life 75% of your net recovery or the total disability income benefits paid or payable to you under this Plan, whichever is less. Your net recovery does not include your legal costs. 75% of your net recovery must be held in trust for Sun Life.

Section 19 - Life Insurance Coverage

General description of the coverage

Basic Life Insurance is designed to ensure that your beneficiary does not face the additional burden of severe financial hardship in the event of your untimely death. This means that you are covered 24 hours per day while you remain an employee of the College and continue to meet the eligibility requirements for insurance under the group contract.

Basic Life Insurance ***(Mandatory)***

Amount of insurance is $25,000.

Accidental Death and Dismemberment Insurance (Mandatory)

In addition to the Basic Life Insurance you have Accidental Death and Dismemberment (AD & D) coverage in the amount of $25,000. Details are provided in the following pages.

Supplementary Life Insurance ***(Optional)***

You may choose additional coverage in units of $10,000 to a maximum of $50,000.

The maximum benefits available under the Plan is $75,000. Unlike the AD&D coverage, there are no exclusions applicable to the Basic and Supplementary Life Insurance.

Change without evidence of insurability

No medical examination or other evidence of insurability is required provided you are actively at work and you apply for the optional life insurance for you or your spouse within 31 days of the following:

- the date you completed your Waiting Period, or
- the date you acquire a Dependent or an additional Dependent, or
- if you were covered for benefits under your spouse's group contract and coverage is terminated because of your spouse's death, or termination of employment, the date such coverage terminates, or
- the date your marital status changes.

What happens if I do not apply within 31 days or I wish to increase the amount of Life Insurance?

You will be required to furnish evidence of insurability to Sun Life. Such insurance coverage will take effect only upon the date your evidence of insurability is approved by Sun Life. It is important to note that it is possible that coverage could be declined. Serious consideration should be given before declining the life benefits at the time the benefits are first offered to you.

You may name the beneficiary of your choice or your estate. In the event of your death, benefits will be paid in the name of the last legally nominated beneficiary you have on file with Human Resources. In the absence of a beneficiary nomination, payment will be made to your estate.

Except as restricted by law, you may change your beneficiary at any time. There are different requirements in the Provinces of Ontario and Quebec related to this matter.

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your Life Insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Accidental Death and Dismemberment

General description of the coverage ***(Mandatory)***

Accidental Death and Dismemberment (AD & D) insurance is provided. This means that if, due to an accident occurring while covered, you die or suffer a dismemberment as listed in the table under *Table of Losses* you may be eligible for benefits. Any death benefit paid under this coverage is in addition to the Basic Life Insurance coverage.

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.

Amount of Insurance is $25,000.

100% of the insurance is payable in the event of accidental death. For other dismemberment situations the amount payable is $25,000 pro-rated in proportion to the percentages identified in the *Table of Losses Chart.*

What the Plan will pay

The Plan will pay for this benefit if you:

- accidentally drown.
- are in an accident or exposed to the elements and, as a direct result, you suffer one of the losses listed below within 365 days of that accident or exposure.

The amount that the Plan will pay is a percentage of the Accidental Death and Dismemberment coverage. The percentage depends on the loss suffered. The following table shows the percentages used to determine the payment.

TABLE OF LOSSES CHART

Loss of life	100%
Loss of both hands	100%
Loss of both feet	100%
Loss of one hand	50%
Loss of one foot	50%
Loss of thumb and index finger on the same hand	33.33%
Loss of use of both arms	100%
Loss of use of one hand and one foot	100%
Loss of use of both legs	100%
Loss of use of one arm and one leg	100%
Loss of use of one arm	50%
Loss of use of one leg	50%
Loss of entire sight of one eye	50%
Loss of entire sight of both eyes	100%
Loss of sight of one eye and either one hand or one foot	100%

Only one of the amounts shown above (the largest applicable) will be paid for injuries to the same limb resulting from any one accident. No more than 100% of the amount of Accidental Death and Dismemberment is payable for all losses due to one accident.

Accidental Loss

- Loss of a hand means that it was severed at or above the wrist.
- Loss of a foot means that it was severed at or above the ankle.
- Loss of a thumb and index finger means that they were severed at or above the first joint from the hand.
- Loss of sight must be total and permanent.

Loss of use of limb must be total, continuous for at least 12 months, and then must be determined to be permanent and irrecoverable before the benefit is payable.

What is not covered

The Plan will not pay AD & D benefits for losses that are the result of:

- intentionally self-inflicted injuries, by firearm or otherwise.
- attempted suicide or suicide while sane or insane.
- flying in, descending from or being exposed to any hazard related to an aircraft while
  - receiving flying lessons.
  - performing any duties in connection with the aircraft (except when such duties are being performed as part of your occupation with the College).
  - being flown for a parachute jump.
  - a member of the armed forces if the aircraft is under the control of or chartered by the armed forces.
- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your AD&D insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Dependent Life Insurance

General description of the coverage ***(Optional)***

Dependent Life Insurance is payable to you and provided to assist you and your family with the additional financial burden should your spouse or dependent children die.

Amount of Insurance

Spouse: $10,000 Each child: $2,500

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your Dependent Life Insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Supplementary Spousal Life Insurance

General description of the coverage ***(Optional)***

(Available only if you have elected Dependent Life Insurance)
To supplement your Dependent Life Insurance, additional life insurance is available to you. In the event of your spouse's death, the Plan will pay the insured amount to you.

Amount of Insurance

Multiples of $10,000 to up to a maximum of $50,000.

Proof of good health

Proof of good health is required for any increase in the amount of spouse insurance. The increase will take effect on the date Sun Life approves the proof of good health.

Coverage during total disability

If you become totally disabled before you terminate employment, retire or reach age 65, whichever is the earliest, your Supplementary Spousal Life Insurance will be continued (provided it was in effect prior to your date of total disability).

Sun Life must receive proof of your total disability within 12 months of the date the disability begins.

Appointing a Beneficiary

Beneficiary Appointments

You may name the beneficiary of your choice or your estate. In the event of your death, benefits will be paid in the name of the last legally nominated beneficiary you have on file with Human Resources. In the absence of a beneficiary appointment, payment will be made to your estate.

Appointment of a Beneficiary in the Province of Ontario

Except as restricted by law, you may change your beneficiary at any time. In the Province of Ontario, the beneficiary is revocable by the insured. This means that you may change your beneficiary appointment at any time without the approval of your beneficiary.

Appointment of a Beneficiary in the Province of Quebec

The Province of Quebec requires that you indicate whether your beneficiary is revocable or irrevocable at the time you make your benefit election. If you have indicated the beneficiary is irrevocable at the time of enrolment, you may only change the beneficiary appointment with the written permission of the current beneficiary. The enrolment form provided by the College will contain this information.

Your beneficiary appointment can be a complex matter, and depending on your specific situation, you may wish to seek legal advice before making a nomination and/or changing an appointment. The necessary form is available from your Human Resources Department.

Life Insurance Conversion

Converting your Life Insurance

When your Life Insurance coverage ends or reduces for any reason other than solely as a result of your request, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

You must apply to convert your life insurance. The College will issue a conversion form to you. This form will confirm details of your employment such as your start date with the College, the amount of insurance coverage in effect at the time of your separation from the College, the termination date of your insurance as well as providing a list of Sun Life numbers where you can call to get more information about your options on an individual policy. You have 31 days from the date your insurance is reduced or ceases to convert your Life Insurance to a private policy with Sun Life.

If you die during the Conversion Period

If you die during this 31 day conversion period, the amount of Life Insurance coverage in effect at the time your coverage is reduced or ceases will be paid to your last named beneficiary as recorded on your file in the Human Resources Department as a death claim.

Converting your spouse's Life Insurance

When your spouse's Life Insurance coverage ends, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health. You have 31 days from the date the insurance is reduced or ceases to convert the Life Insurance to a private policy with Sun Life. This is not available for dependent children.

If your spouse dies during the Conversion Period

If your spouse dies during this 31 day conversion period, the amount of Life Insurance coverage in effect at the time the coverage is reduced or ceases will be paid to you.

Section 20 - Submission of Claims

Making an Extended Health Care Claim

You are required to pay the full cost for your Extended Health Care expenses and then submit your claims for reimbursement to Sun Life with the following exception:

Within six months of the date of ratification of the Collective Agreement effective September 1, 2005, a point-of-sale drug card will be implemented. With this card, you will pay only 15% of the total cost of the covered medication and the provider will be responsible for obtaining reimbursement of the balance from Sun Life. Specific administrative details will be provided prior to the implementation date.

Time limits for filing a claim

Claims must be received by Sun Life within the earliest of:

- 548 days (18 months) following the date on which the expense was incurred,
- 90 days following the end of your Extended Health Care coverage, or
- 90 days following the termination of the Extended Health Care coverage provision.

Before submitting a claim, you will need to consider the co-ordination of benefits provisions to ensure that you are submitting the claims appropriately.

Co-ordination of benefits
(Coverage under more than one plan)

If you are covered for Extended Health Care under this Plan and you and your spouse are covered under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards.

These standards determine where you should send a claim first. Here are some guidelines:

- if you are claiming expenses for your spouse and the spouse is covered for those expenses under another plan, you must send the claim to your spouse's plan first.
- if you are claiming expenses for your children, and both you and your spouse have coverage under different plans, you must claim under the plan of the parent with the earlier birthday (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 maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.
- if your spouse is over age 65 and eligible for coverage under the Ontario Drug Benefit Program (ODB) there are specific rules to follow. Contact your College Benefits Administrator for further details.

The Claims Process

If you are submitting your first claim for benefits, the claim form can be obtained from your College Benefits Administrator. Sun Life will send the payment directly to you along with a pre-printed claim form for you to use when you submit your next claim. Each time you file a claim you must follow the same process.

In the event you misplace your personalized claim form, a generic form can be obtained from your College Benefits Administrator.

Prescription Drug Claims - Drug Card

- Complete all sections of the claim form, sign it, date it.
- Forward it to the Sun Life claims office. The appropriate address is noted on the claim form making sure that all your receipts and any necessary medical information is attached.
- Keep a copy of the form and your receipts for future reference.

Effective March 22, 2006, you will be issued a pay direct "poin-of-sale" prescription drug card. By presenting this card to your pharmacist you will only need to pay 15% of the cost of your medications. If you do not use the card, your reimbursement could be affected due to the mark up of the cost of the drugs by the pharmacist.

If you have co-ordination of benefits with your spouse, the claim process will not change, and you will still be required to send in paper claims for his claims (and dependent children if spouse's plan is primary payer).

If your spouse has a drug card, you must ensure that the pharmacist has the information on both cards and the co-ordination of payments will be done at the point-of-sale by the pharmacist and you will not have to do a paper claim.

Private Duty Nursing Claims

Private Duty Nursing Services must be ordered by a doctor for the treatment of an illness. In addition to the claim form and the receipt for the expenses, you must include a letter from your doctor. This letter should describe the nature of your disability or your Dependent's disability, a diagnosis, how the particular service will improve/stabilize your or the patient's condition and the length of time the service will be required. Before any expenses for Nursing care can be reimbursed, Sunlife requires that a Nursing questionnaire is completed by your doctor for review. Please contact Sunlife to obtain this questionnaire.

Medical Supplies and Equipment

Medical supplies and equipment must be ordered by a doctor for the treatment of an illness. In addition to the claim form and the receipt for the expenses, you must include a letter from your doctor. This letter should describe the nature of your disability or your Dependent's disability, a diagnosis, how the particular supplies or equipment will improve/stabilize your or the patient's condition and the length of time the supplies or equipment will be required.

How long will it take for my claim to be processed?

Provided you have sent all the necessary information and completed the form satisfactorily your claim should be processed within 7 days.

Following up on a claim

In the event a payment has taken longer than anticipated you may follow-up on the status of the payment by contacting Sun Life directly.

I am the survivor of a deceased employee. How do I make a claim for benefit?

If you are entitled to and have elected survivor benefits you will be required to follow the process stated above. Your Social Insurance Number will be your Identification number, not that of your deceased spouse.

Out-of-Province Claims

OHIP first

- Your claim for expenses incurred outside the province must be submitted to OHIP first.
- Original receipts should be included with your claim and you should keep a copy for your records.

Sun Life second

- The balance of the claim not paid by OHIP should be submitted to Sun Life, using the normal claim form for your Group.
- The OHIP reimbursement statement and copies of your receipts should be attached to the Sun Life claim form.
- Be sure to keep a copy of the information sent to Sun Life for your records.

Out-of-Canada Claims

OHIP first

- Your claim for expenses incurred outside Canada must be submitted to OHIP first.
- Original receipts should be included with your claim and you should keep a copy for your records.

Sun Life second

- The balance of the claim not paid by OHIP should be submitted to Sun Life, using the normal claim form for your Group.
- The OHIP reimbursement statement and copies of your receipts should be attached to the Sun Life claim form.
- Be sure to keep a copy of the information sent to Sun Life for your records.

Contacting Sun Life

Sun Life's web address is: www.sunlife.ca
Sun Life's e-mail address is: askus sunlife.com
Sun Life's number in Toronto is: 416-753-4300
Sun Life's toll-free number is : 1-800-361-6212
Should you require assistance, please contact your College Benefits Administrator to obtain a brochure with additional information on Sun Life contacts.

Making a Dental Claim

Time limits for filing a claim

In order to pay benefits, Sun Life must receive a claim no later than the earliest of:

- the end of the calendar year following the year during which you incur the expenses,
- 90 days after the end of your Dental Care coverage.
- 90 days following termination of the Dental Care provision.

Co-ordination of benefits
(Coverage under more than one plan)

If you or your spouse are covered for Dental Care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards.

The Claims Process

Claims can be submitted electronically by your dentist, or if you are submitting your first claim for benefits, the claim form can be obtained from your College Benefits Administrator.

Sun Life will send the payment directly to you along with a pre-printed claim form for you to use when you submit your next claim. Each time you file a claim you must follow the same process.

- ask your Dentist to complete the applicable sections of the claim form.
- you complete the applicable sections of the claim form, sign it, attach any relevant information and forward it to the Sun Life claims office. The appropriate address is noted on the claim form.
- keep a copy of the claim form and your receipts for future reference.

In the event you misplace your personalized claim form, a generic form can be obtained from your College Benefits Administrator.

Orthodontic Claims

Although most orthodontists will quote a single amount for the full course of treatment covering several years, orthodontic expenses will be reimbursed based on a monthly or quarterly basis as treatment is rendered. The Plan will not prepay services that have not been rendered.

How long will it take for my claim to be processed?

Provided you have sent all the necessary information and the claim form has been completed satisfactorily, your claim should be processed within 7 days.

Following up on a claim

In the event a payment has taken longer than anticipated, you may follow-up on the status of the payment by contacting Sun Life directly.

Contacting Sun Life

Sun Life's web address is: www.sunlife.ca
Sun Life's e-mail address is: askus sunlife.com
Sun Life's number in Toronto is: 416-753-4300
Sun Life's toll-free number is : 1-800-361-6212
Should you require assistance, please contact your College Benefits Administrator to obtain a brochure with additional information on Sun Life contacts.

Making a Claim for Long Term Disability Benefits

When and how to make a claim
Your responsibilities

You are responsible for notifying your College that you are disabled and obtaining the following forms from your College Benefits Administrator:

a) Employee's Statement
b) Authorization to Communicate form
c) Attending Physician's Statement of Disability
d) Application for Canada Pension Plan benefits (CPP)
e) Canada Pension Plan (CPP) Assignment Form

This should be done at least 30 days prior to the end of your elimination period.

Your formal claim for Long Term Disability should ideally be submitted as soon as possible, usually within 90 days after you complete the elimination period.

You complete forms a, b and e and forward them to Sun Life.

You must sign the Attending Physician's Statement of Disability (form c) and give it to your doctor. You must also contact the Income Security Program office, Human Resources Development Canada (HRDC), to make an application for Canada Pension Plan disability benefits (form d).

You are responsible for payment of any charges for having medical forms completed. These forms include those described above, supplementary medical statements and any other forms that may have to be completed by a doctor.

Your doctor's responsibility

Once your doctor has completed the Attending Physician's Statement of Disability (form c), you or your doctor may send it directly to Sun Life or, if your prefer, you may return it to your College Benefits Administrator to send to Sun Life.

Your employer's responsibility

The College must complete the Employer's Statement and forward it to Sun Life.

Time lines for making a claim

Formal claim must be made no later than 90 days after you complete your elimination period. Ceasing to be actively at work with the College does not, by itself, mean that you are totally disabled.

Claim is received by Sun Life

Sun Life will begin processing your claim once all the completed claim forms have been received.

Your claim cannot be processed until Sun Life has received the Employee's Statement (including Authorization to Communicate Form), Employer's Statement and the Attending Physician's Statement of Disability. Benefits are paid monthly, in advance.

Incomplete or additional information

If additional information is needed to make a decision on your claim, Sun Life will notify the College by letter as soon as possible. Your College Benefits Administrator will, in turn, notify you that further information is needed. Any expenses associated with acquiring the additional information will be your responsibility.

Claim is reviewed by Sun Life

Sun Life claims personnel and practising doctors review your claim to determine if you qualify for disability benefits in accordance with the terms of your contract. The nature of the claim will determine whether a specialist(s) report(s) is required.

How will I know if my claim has been processed?

Sun Life will send the College a letter confirming the amount of your disability benefits, the date they will commence and the duration for which benefits are approved (if known). Your College Benefits Administrator will forward this information along to you.

How long will it take to process my LTD claim?

Assuming all the forms have been completed fully and no follow-up is required by Sun Life, it takes approximately 4-6 weeks for a Long Term Disability claim to be processed.

If there are any complications with the forms, additional time would be added to the process resulting in a period of time when you could be without remuneration.

Every attempt is made to ensure this does not happen. Continuous contact between you and your College Benefits Administrator will

help to minimise the situation. In this event, you may apply for Employment Insurance Sick benefits.

What can I do if my claim is declined?

Sun Life will advise the College Benefits Administrator that your claim has been denied and Sun Life will provide an outline of the procedures and the type of medical information required for reconsideration of your claim. You may appeal this decision through Sun Life's appeal process. Your claim will be reconsidered upon submission of this information.

Your claim will be reconsidered provided you submit new medical information for review. In order to effectively re-evaluate your claim, all outstanding information requested in the decline letter should be provided.

Based on the new medical information if your claim is denied and all normal avenues of review through your College Benefits Administrator have been exhausted, you have the right to refer your claim to your Local Union Representative or the Support Staff Joint Insurance Committee (JIC). Information about the JIC is contained in the Support Staff Collective Agreement.

Discrepancies in benefit payment amounts

It is recommended that you check your benefit payment amount each month to ensure it is correct. In the event you discover there is a discrepancy, it is important for you to contact your College Benefits Administrator so that the appropriate adjustment can be made. If you have been overpaid, a re-payment arrangement can be worked out for you; if you have been underpaid, Sun Life will be required to make the correction and issue payment.

Making a Life Insurance Claim

How to make a claim

Your College Benefits Administrator must be contacted immediately, and will assist you or your beneficiary with the process associated with filing a death claim.

Your Death Claim

In the event of your death, the following must occur as soon as possible after your death:

- A claim form must be completed by the College.
- A claim form must be completed by your beneficiary.
- The completed claim forms along with a death certificate from your attending doctor or funeral director must be forwarded to Sun Life in order for the claim to be adjudicated.

For Accidental Death & Dismemberment Claims Applicable only to employees

If you suffer a loss other than death, ***the following must occur*** within 6 months of the loss:

- A claim form must be completed by the College.
- A claim form must be completed by you.
- The completed claim forms along with an Attending Physician's Statement clearly indicating the date and details of the accident, the nature of the injury, the date of loss and the degree of loss, must be forwarded to Sun Life in order for the claim to be adjudicated.

Death Claim for your Dependent(s)

In the event of the death of a Dependent, ***the following must occur*** as soon as possible after the death of a Dependent:

- A claim form must be completed by the College.
- A claim form must be completed by you.
- The completed claim forms along with a death certificate from your Dependent's attending doctor or funeral director must be forwarded to Sun Life in order for the claim to be adjudicated.

It normally takes 3-4 weeks to process a claim, however this may vary depending on the circumstances of each case. Sun Life will make every effort to keep the College Benefits Administrator informed of the status of the claim.

Respecting Your Privacy

Within the Sun Life Financial group of companies, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with insurance and investment products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees and representatives who are responsible for the administration and servicing of your contract(s) with us, or any other person whom you authorize. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

To find out about our Privacy Policy, visit our Web site at www.sunlife.ca or call 1 800 361-2128 and request that a copy of our Privacy Brochure be sent to you.