Sun Life

your group benefits

International Students at a participating Primary School, High School or College

Contract Number 50659
Effective August 1, 2022

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General Information

About this booklet

The information in this benefits booklet is important to you. It provides the information you need about the group benefits available through your participating educational institution with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life group of companies.

Your group benefits may be modified after the effective date of this booklet. The contract holder will receive written notification of changes to your group plan. Your Administrator will notify you of these changes.

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

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

Eligibility

To be eligible for group benefits, you must be a student:

- who is not a Canadian citizen or permanent resident, or
- who is a Canadian citizen but is not entitled to benefits under any Provincial Medicare Plan.

Enrolment

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

You may refuse Extended Health Care coverage because comparable coverage is provided:

- under a special arrangement with the province of Quebec

- under a special arrangement with the Canadian International Development Agency (CIDA), or
- as a dependent child of a diplomat on assignment in Canada.

If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time. You must notify your administrator within 31 days of the date the coverage ends. If you do not request Extended Health Care coverage within this time limit, you will have to provide proof of good health at your own expense.

When coverage begins

Your coverage begins on the date you become eligible for coverage or the date you arrive in Canada, whichever is later. However, if you arrive in Canada before registration (maximum 6 weeks), your coverage may begin on the date of your arrival.

If you are hospitalized on the date coverage would normally begin, your coverage will not begin until the day after you are discharged from hospital.

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

Changes affecting your coverage

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

For example, your student status may change, or the contract holder may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

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

- if proof of good health is required, the change cannot take effect before Sun Life approves the proof of good health.
- if you are not actively pursuing your studies when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to actively pursuing your studies.

Updating your records

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

- change of name.
- change of beneficiary.

Accessing your records

For insured benefits, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at *www.mysunlife.ca*.

- our Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

As a student, your coverage will end on the earlier of the following dates:

- the date you are no longer an eligible student.
- the date you terminate your studies, except when you remain in Canada awaiting graduation.
- the date you are eligible under any government health plan.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

You may terminate the Extended Health Care benefit because comparable coverage is provided under this, or another group contract, as indicated under *Enrolment*. In this case, coverage under the Extended Health Care benefit ends on the date you choose.

Replacement coverage

The group contract will be interpreted and administered according to all legislation concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact your administrator to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Coordination of benefits

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

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

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

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

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

Claims for you should be submitted in the following order:

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

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

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

Medical examination

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, we will not pay any benefit.

Recovering overpayments

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

Assignments

For Life benefits, no rights or interests can be assigned.

For all other benefits, we reserve the right to refuse assignments.

Definitions

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

Accident

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

Actively pursuing studies

Perform all the usual and customary duties of a student and be present for any scheduled activities.

Administrator

The Student Health Network.

Doctor

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

Illness

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

In-patient

A patient who is hospitalized for a period of more than 24 hours, if this has been ordered by a doctor.

Out-patient

A patient who is receiving care in a hospital, but not as an in-patient.

Medically necessary	Treatment, services or equipment eligible under the Régie de l'assurance-maladie du Québec (RAMQ) and recognized by Sun Life as effective, appropriate and required for diagnosis, care or treatment of a specific medical condition, illness or accident.
Preferred provider	A doctor, hospital or other health care facility who has an agreement in effect with Sun Life at the time services are rendered.
Pregnancy	Pregnancy, childbirth, miscarriage, abortion and conditions which result directly or indirectly from any of these.
Reasonable and customary charges	Charges which are usually made in the absence of this or any similar coverage, for a specific type or care, service or supply, based on representative fees and prices for foreign students in the geographic area in which the charges were incurred, as evaluated by Sun Life.
Student	A student or visiting scholar of foreign nationality who is registered as a full-time, part-time or research student at one of the participating educational institution.
We, our and us	We, our and us mean Sun Life Assurance Company of Canada.

Basic Health Care

General description of the coverage

Basic Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. To qualify, the supplies and services must be covered by the Régie de l'assurance-maladie du Québec (RAMQ) on the date eligible expense is made.

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

Reference to Doctor may also include a nurse practitioner

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

The benefit year is from August 15 to August 14.

Deductible

There is no deductible for this coverage.

Reimbursement level

We will cover:

- 100% for care or services obtained from a Preferred Provider, or
- reasonable and customary charges for care or services obtained elsewhere.

We have established a Preferred Provider's network, you must contact us before incurring expenses.

Maximum benefit

We will pay for eligible expenses as determined by the Régie de l'assurance-maladie du Québec (RAMQ) for foreign students, unless otherwise specified.

Lifetime maximum benefit

Under Basic Health Care, the maximum amount we will pay is $1,500,000 per person.

Hospital expenses

We will cover the costs of in-patient hospitalisation in a ward hospital room up to a maximum of:

- 2 days in the event of a natural childbirth (a longer period may apply if three are complications). For a pregnancy that began prior to the date of coverage, the delivery will be reimbursed only if the student was covered for a similar benefit in Canada the day preceding the effective date of coverage and for a period of at least 12 consecutive months.
- 10 days in the hospital nursery for a premature baby only, if the baby is born after a gestation period of less than 37 weeks.
- 30 days for psychiatric reasons.
- 60 days for any other reason.

The above limits may be extended if your medical condition does not permit your return to your country of origin.

We will cover the cost of transportation for your return to your country of origin if your medical condition permits and if, in our opinion, such return is warranted.

We will also cover the cost of out-patient services in a hospital including emergency ward medical services.

An *emergency* is an acute, unexpected illness that requires immediate attention.

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. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

Medical services and equipment

We will cover the costs for the medical services listed below:

- abortion performed by a doctor in a hospital or in a Preferred Provider abortion clinic.
- dental or oral surgery performed in a hospital, when ordered by a doctor. The maximum amount payable is $250 for each person in a benefit year.
- medical, surgical, anaesthetic charges and consultations by specialists rendered by a health professional such as a doctor, surgeon or anaesthetist up to the amount specified (for foreign students) in the Manuel des médecins omnipraticiens or in the Manuel des médecins spécialistes provided by the Régie de l'assurance-maladie du Québec. These specialists must be considered as such by the Régie.
- psychiatric services rendered by a licensed psychiatrist, up to a maximum amount payable of $10,000 for each person in a benefit year.
- medical visits for contraception purposes.
- breast prostheses required as a result of a mastectomy, up to a maximum of $200 per breast in a benefit year.
- periodic check-ups or examinations.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused you to incur medical expenses.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us the amount by which the sum of the benefits paid under this plan and your net recovery exceeds 100% of the actual cost of the medical expenses for which benefits were paid. Your net recovery does not include your legal costs.

We have the right to withhold or discontinue payments if you refuse or fail to comply with any of these terms.

When coverage ends

Basic Health Care coverage will end as specified in *General Information*.

Payments after coverage ends

If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability until the earliest of the following:

- the date you are discharged from the hospital.
- the end of the 30 day period following the end of coverage.
- this benefit is terminated.

For the purpose of this provision, a student is totally disabled if prevented by illness from performing usual and customary duties as a student.

What is not covered

We will not pay for the costs of:

- services or supplies payable in whole or in part under any government-sponsored plan or program including the Société de l'assurance automobile du Québec, except for user fees, extra billing, and other expenses in excess of those payable under the government-sponsored plan or program, if the legislation allows their payment under private plans.
- services or supplies which are not payable by Régie de l'assurance-maladie du Québec for Québec residents.
- expenses incurred in connection with rest cures, travel for health reasons or pregnancy tests.
- telephone consultations made by a doctor with respect to a person's illness or injury.
- services or supplies which are not listed in this benefit.
- services or supplies for which no charge would have been made in the absence of this coverage.
- services or supplies for which you are not required to make payment, or where payment is received as a result of legal action or settlement.
- cosmetic surgery unless medically necessary following an accident while you are covered.
- expenses incurred while in a hospital following an accident, illness or pregnancy (except for asthma, diabetes and epilepsy) for which you were confined in a hospital or received medical care in the 6 month period prior to the date your coverage began. However, this limitation will not apply if:
    - the expenses are incurred more than 12 months after the commencement of the present coverage, or

  - the present plan replaces a similar coverage the student had with a group insurance plan offered by a recognised Canadian educational institution for a period of 12 consecutive months immediately prior to the present coverage.

- replacement of any existing medical appliance.
- any organ transplant unless it is solely due to an accident, a virus or a fulminant disease while you are covered under this plan.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- services or supplies that are not usually provided to treat an illness, including experimental treatments.

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

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- commission or attempted commission of a criminal offence by the covered person.

Pre-existing conditions

A medical condition (except asthma, diabetes and epilepsy) for which you have consulted a physician, been treated by a physician or been prescribed medication during the 3 month period (12 month period for travel benefit) preceding the effective date of insurance. Pregnancy is considered a pre-existing condition if delivery takes place within the first 30 weeks following initial registration in the plan, whether or not it was diagnosed during the 3 month period preceding the effective date of insurance. For insurance purposes, such a

condition will cease to be considered a pre-existing condition on the date you have completed a period of 12 consecutive months following the effective date of insurance without any physician consultation, medical treatment or drug prescription for this condition. Even if you have not consulted a physician during the 3 month period preceding your arrival in Canada, the medical condition is considered a pre-existing medical condition by the insurer if the state of health shows obviously that the condition existed at the time of arrival in Canada. Also, any state of condition for which symptoms have been ignored or for which a medical advice has not been followed or for which recommended investigation treatment, examination or intervention have not been done, are considered a pre-existing medical condition. The pre-existing condition applies to all cases of congenital disease, whether or not diagnosed.

The pre-existing condition will not apply if this plan replaces a similar coverage you had with a group insurance plan offered by a recognized Canadian educational institution, for a period of 12 consecutive months immediately prior to the present coverage.

Integration with government programs

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

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

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

Lumino Health Virtual Care

The services offered through Lumino Health Virtual Care are provided by Dialogue. These services are not insured or administered by Sun Life.

If you are covered for Extended Health Care coverage, you and your covered dependents will have access to Dialogue services.

Lumino Health Virtual Care offers a variety of services including access to medical professionals. To learn more about the services provided by Dialogue, or to use these services, please visit *https://luminovc.dialogue.co/*.

Liability and responsibility of Sun Life

Sun Life will not be held liable for any acts or omissions of any person or organization providing services directly or indirectly in connection with Dialogue.

When and how to make a claim

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

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

- 180 days after the date you incur the expenses, or
- 90 days after the end of your Basic Health Care coverage, whichever is earlier.

Extended Health Care (Medicare Supplement)

General description of the coverage

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.

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

Reference to Doctor may also include a nurse practitioner

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

The benefit year is from August 15 to August 14.

Deductible

There is no deductible for this coverage.

Benefit year maximum

We will not pay more than $7,500 per person for each benefit year for all services or supplies under Extended Health Care, excluding prescription drugs and emergency services incurred outside Canada.

Prescription drugs

We will cover 100% of the cost of drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary that are prescribed by a doctor or dentist and are obtained from a pharmacist.

We will only pay for quantities that can reasonably be used in a 30 day period.

Benefit year maximum

We will not pay more than $10,000 per person for each benefit year for all prescription drugs.

Other health professionals allowed to prescribe drugs

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

Hospital expenses

We will cover 100% of the costs for hospital care up to the rate of a semi-private room.

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. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Convalescent hospital in Canada

We will cover 100% of the costs for hospital care up to the rate of a semi-private room and for a maximum of 60 days (30 days if due to psychiatric reasons) if this care has been ordered by a doctor and as long as it begins within 14 days of release from the hospital and it is primarily for rehabilitation, and not for custodial care.

However, this limit may be extended if your medical condition does not permit you to return to your country of origin.

If your medical condition permits you to return to your country of origin and if, in the opinion of Sun Life, such return is warranted, then charges in excess of the regular transportation costs will be paid for your return trip.

For purposes of this plan, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

Expenses out of your province

We will cover emergency services while you are outside the province where you live.

We will cover the cost of:

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

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

Emergency services

We will pay 100% of the cost of covered emergency services.

We will only cover emergency services obtained within 60 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

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

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

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

An emergency ends when you are medically stable to return to the province where you live.

Emergency services excluded from coverage

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.

- services relating to an illness or injury which caused the emergency, after such emergency ends.

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

- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.

- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Emergency services outside Canada

Expenses incurred for emergency services outside Canada are subject to a lifetime maximum of $1,000,000 per person or, if lower, any other applicable lifetime maximum.

Repatriation benefit

If you are diagnosed as terminally ill with a life expectancy of 12 months or less and your medical condition is deemed stable by us, we will pay expenses that we consider to be reasonable for your return by the most direct route to the air terminal nearest your normal residence in your Home Country.

Eligible expenses include economy airfare (and stretcher, if required) and return airfare for a qualified medical attendant (if certified as necessary by the attending doctor), including, if required, overnight hotel and meal expenses for the medical attendant.

If you refuse to be repatriated, any further expenses payable under the group plan will not be covered. You are responsible for these expenses. You may be ineligible for other international student health insurance contracts issued by us.

In the event of your death, we will pay up to $15,000 for the expenses of returning your remains by the most direct route to the air terminal nearest your normal residence in your Home Country. Eligible expenses include the cost of preparation and transportation of remains, documentation and standard shipping container.

Burial cost in the location where death occurs

In the event of your death, if the burial or cremation occurs in the location where death occurs, instead of repatriation to your Home Country, we will pay up to $5,000 for eligible expenses including the transportation of the remains to a funeral home, the cost of a casket, preparation of the remains, a burial plot and internment.

Medical services and equipment

We will cover 100% of the costs for the medical services listed below when ordered by a doctor (the services of a licensed optometrist, ophthalmologist or dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $5,000 per person per benefit year.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Expenses incurred outside Canada for emergency services will be paid based on the conditions specified above for emergency services under *Expenses out of your province*.

- laboratory tests performed by a commercial laboratory, CLSC or health services department of an educational institution for the diagnosis of an illness. Tests performed in a doctor's office or by a pharmacy are not covered.

- MRI (magnetic resonance imaging) and CAT scans.

- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received. The maximum amount payable is $1,000 per person in a benefit year.

- services of an ophthalmologist or licensed optometrist, up to a maximum of one examination per person in a 2 year period.

- equipment rented, or purchased at Sun Life's request, that is for temporary therapeutic use. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.

- casts, splints, trusses, braces or crutches.
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per person in a benefit year.
- purchase and repairs of artificial limbs, eyes and larynx, excluding myoelectric appliances.
- pressure gradient hose.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- orthotic inserts for shoes.
- electronic heart pacemaker.
- x-ray examinations done in an approved radiological facility for diagnosis of an illness.
- ultrasounds done in a private clinic for diagnosis of an illness. Ultrasounds related to pregnancy are covered as of the 18th week of gestation up to a maximum of 2 per pregnancy.
- electrocardiograms, mammographies and thermographies done in a private clinic.

Paramedical services

We will cover 100% of the costs of paramedical specialists listed below:

- licensed speech therapists or podiatrists up to a maximum of $500 per person per specialty in a benefit year. These services are limited to one visit per specialty per day.

- licensed athletic therapists, acupuncturists, osteopaths (this category of paramedical specialists also includes osteopathic practitioners), physiotherapists, massage therapists (when ordered by a doctor), or chiropractors, including a maximum of one x-ray examination per specialty each benefit year, up to a combined maximum of $1,000 per person in a benefit year. These services are limited to one visit per specialty per day.
- licensed homeopaths or naturopaths up to a combined maximum of $500 per person in a benefit year. These services are limited to one visit per specialty per day.
- licensed psychologists or psychotherapists up to a combined maximum of $500 per person in a benefit year.

If you recover damages from another person

We have the right to part of any money you recover through legal action or settlement from another person, organization or company who caused you to incur medical expenses.

If you decide to take legal action, you must comply with the applicable terms of the group contract concerning legal action.

If you recover money, you must pay us the amount by which the sum of the benefits paid under this plan and your net recovery exceeds 100% of the actual cost of the medical expenses for which benefits were paid. Your net recovery does not include your legal costs.

We have the right to withhold or discontinue payments if you refuse or fail to comply with any of these terms.

When coverage ends

Extended Health Care coverage will end when as specified in *General Information*.

Payments after coverage ends

If you are totally disabled when your coverage ends, benefits will continue for expenses that result from the illness that caused the total disability until the earliest of the following:

- the date you are discharged from the hospital.
- the end of a 30 day period following the end of coverage.
- the date this benefit is terminated.

For the purpose of this provision, a student is totally disabled if prevented by illness from performing usual and customary duties as a student.

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, including the Société de l'assurance automobile du Québec, except as described below under *Integration with government programs*.
- expenses incurred in connection with rest cures, travel for health reasons or pregnancy tests.
- telephone consultations made by a doctor with respect to a person's illness or injury.
- services or supplies which are not listed in the benefit.

- services or supplies for which no charge would have been made in the absence of this coverage.
- services or supplies for which a person is not required to make payment, or where payment is received as a result of legal action or settlement.
- cosmetic surgery and dental surgery, unless medically necessary following an accident while a person is covered.
- expenses incurred while in a hospital following an accident, illness or pregnancy (except for asthma, diabetes and epilepsy) for which you are confined in a hospital or received medical care in the 6 month period prior to the date your coverage begins. However, this limitation will not apply if:
  - the expenses are incurred more than 12 months after the commencement of the present coverage, or
  - the present plan replaces a similar coverage you had with a group insurance plan offered by a recognised Canadian educational institution for a period of 12 consecutive months immediately prior to the present coverage.
- replacement of any existing medical appliance.
- any organ transplant unless it is solely due to an accident, a virus or a fulminant disease while the person was covered under this plan.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.

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

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- commission or attempted commission of a criminal offence by the covered person.

Pre-existing conditions

A medical condition (except asthma, diabetes and epilepsy) for which you have consulted a physician, been treated by a physician or been prescribed medication during the 3 month period (12 month period for travel benefit) preceding the effective date of insurance. Pregnancy is considered a pre-existing condition if delivery takes place within the first 30 weeks following initial registration in the plan, whether or not it was diagnosed during the 3 month period preceding the effective date of insurance. For insurance purposes, such a condition will cease to be considered a pre-existing condition on the date you have completed a period of 12 consecutive months following the effective date of insurance without any physician consultation, medical treatment or drug prescription for this condition. Even if you have not consulted a physician during the 3 month period preceding your arrival in Canada, the medical condition is considered a pre-existing medical condition by the insurer if the state of health shows obviously that the condition existed at the time of arrival in Canada. Also, any state of condition for which symptoms have been ignored or for which a medical advice has not been followed or for which recommended investigation treatment, examination or intervention have not been done, are considered a pre-existing medical condition. The pre-existing condition applies to all cases of congenital disease, whether or not diagnosed.

The pre-existing condition will not apply if this plan replaces a similar coverage you had with a group insurance plan offered by a recognized Canadian educational institution, for a period of 12 consecutive months immediately prior to the present coverage.

Integration with government programs

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

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

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

Lumino Health Virtual Care

The services offered through Lumino Health Virtual Care are provided by Dialogue. These services are not insured or administered by Sun Life.

If you are covered for Extended Health Care coverage, you and your covered dependents will have access to Dialogue services.

Lumino Health Virtual Care offers a variety of services including access to medical professionals. To learn more about the services provided by Dialogue, or to use these services, please visit *https://luminovc.dialogue.co/*.

Liability and responsibility of Sun Life

Sun Life will not be held liable for any acts or omissions of any person or organization providing services directly or indirectly in connection with Dialogue.

When and how to make a claim

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

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

- 180 days after the date you incur the expenses, or
- 90 days after the end of your Extended Health Care coverage, whichever is earlier.

Emergency Travel Assistance

General description of the coverage

If you are faced with a medical emergency when travelling outside of the province where you live, AZGA Service Canada Inc. (*Allianz Global Assistance*) can help.

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

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

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

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

Getting help

At the time of an emergency, you or someone with you must contact Allianz Global Assistance. If contact with Allianz Global Assistance cannot be made before services are provided, contact with Allianz Global Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

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

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Meals and accommodations expenses

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

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

Travel expenses home if stranded

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

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

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

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

Travel expenses of family members

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

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

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

Repatriation

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

Vehicle return

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

Lost luggage or documents

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

Coordination of coverage

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

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

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

Limits on advances

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

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

Reimbursement of expenses

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

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

Your responsibility for advances

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

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

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

Limits on Emergency Travel Assistance coverage

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

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

- a rebellion, riot, military up-rising, war, labour disturbance, strike, nuclear accident or an act of God.

- the refusal of authorities in the country to permit Allianz Global Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Allianz Global Assistance

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

Life Coverage

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

Life coverage for you

Amount

Your Life benefit is $3,000.

Coverage ends

Your coverage will end as specified in *General Information*.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and desire to designate a minor as your beneficiary, you may wish to designate someone else to receive the death benefit in trust for the minor. If a trustee is not designated, applicable legislation may require that a death benefit payable to a minor be paid instead to a court, or guardian or public trustee. If you reside in Québec and have designated a minor as beneficiary, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively (and regardless of whether you reside outside or in Québec), you may wish to consider designating your estate as beneficiary and provide the executor(s) with directions in your will as to the entitlement of the minor. You are encouraged to consult a legal advisor.

Converting Life coverage

If your Life coverage ends or reduces for any reason other than 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.

The request must be made within 31 days of the reduction or end of the Life coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your administrator for details.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from your administrator.

Accidental Death and Dismemberment

General description of the coverage

Accidental Death and Dismemberment coverage provides benefits if, due to an accident occurring while covered, you die or suffer any of the losses listed in the table under *What we will pay*. Any death benefit paid under this coverage is in addition to the Life coverage.

Accidental coverage for you

Amount

Your Accidental Death and Dismemberment coverage is equal to the amount shown in the following Table of Losses.

Coverage ends

Your coverage will end as specified in *General Information*.

What we will pay

We 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 one year of that accident or exposure.

TABLE OF LOSSES

Loss of life	$5,000
Loss of both hands or both feet	$10,000
Loss of one hand or one foot, and entire sight of one eye	$10,000
Loss of one arm or one leg	$7,500
Loss of one hand or one foot	$5,000
Loss of thumb and index finger on the same hand	$1,000
Loss of entire sight of one eye	$1,500
Loss of entire sight of both eyes	$10,000

Only the largest percentage is paid for injuries to the same limb resulting from the same accident. We will not pay more than $10,000 of coverage if an accident results in more than one loss.

Loss of an arm means that it was severed at or above the elbow. 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 or finger means that it was severed at or above the first joint from the hand. Loss of sight must be total and permanent.

What is not covered

We will not pay for losses that are the result of:

- self-inflicted injuries, by firearm or otherwise.
- bodily injury sustained while operating a motor vehicle with a blood alcohol content over the permissible level stipulated in the criminal code.
- attempted suicide or suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions.
- 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.
  - 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.

- participation in a criminal offence.
- bodily or mental infirmity or disease, or medical or surgical treatment of this infirmity or disease.
- infection unless it is caused by an external wound that can be seen and which was sustained accidentally.

Converting coverage

If your Accidental Death and Dismemberment coverage ends or reduces, for any reason other than your request, and if you apply to convert your group Life coverage to an individual Life policy, you may also apply at that time to have an Accidental Death benefit attached to the individual Life policy.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact your administrator for details.

When and how to make a claim

For any loss other than death, the claim must be received by Sun Life within one year after the loss.

If the claim is the result of a death, the claim should be made as soon as possible after the death occurred.

Claim forms are available from your administrator.

Respecting your privacy

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

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

This group plan arranged by:

THE STUDENT HEALTH NETWORK