



Your Benefits

EMPLOYEE BENEFITS

for

**Partial-Load Academic Employees
of the Ontario Colleges
of Applied Arts
and Technology**

**Contract Number 50832 and 50090
Effective January 1, 2007**

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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 Academic 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.

Benefits for Partial-Load employees were established under the Academic Pay Equity Plan as required by the 'Pay Equity Act, (1987)'. The effective date for participation in benefits was July 1, 1990.

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, 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 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 Union Local Representative.

About the Group Insurance Benefits Program

The group insurance benefit program and the cost-sharing arrangements provided to the CAAT Academic Partial-Load Employee Group are a result of negotiations and are set out in the Academic Staff Collective Agreement.

Section 2 - Roles and Responsibilities

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

The College Compensation and Appointments Council (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.

**About the Joint
Insurance
Committee**
(JIC)

The Academic JIC consisting of representatives of OPSEU, CAAT and the Council has been established under the Terms of Reference in the Academic Collective Agreement. The committee meets on a regular basis to discuss group insurance benefits matters. 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 are responsible to:

- maintain all records regarding an employee's coverage.
- ensure the group contracts are adhered to.
- communicate the provisions of the group contract to employees.

Each College has a designated individual(s) in the Human Resources Division and/or Payroll Services who is responsible for the group insurance benefit program.

OPSEU
*(the employee's
representative)*

OPSEU is responsible to:

- represent employees covered by the Academic 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 Academic JIC as outlined in the Collective Agreement.

Sun Life
(Insurance Company)

The Insurance Company is responsible to:

- adjudicate and pay 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 the Human Resources Department at your College informed about changes that may affect the status of your benefits.

Section 3 - Definitions

Actively At Work You are considered to be 'actively at work' if you are performing all the usual and customary duties of the job with the College for the scheduled number of hours.

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 practise 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.

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Your partner who is qualified as your spouse will cease to qualify as a Dependent on the earlier of:

- the date you elect to disqualify that partner as your spouse, or
- the date that partner ceases to meet the requirements of a person eligible to be qualified as your spouse.

Children under age 21

- 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 age 21 but under age 25 (Student)

An 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.

The completed "**Handicapped Child Coverage**" form must be forwarded to Sun Life to ensure continuation of coverage.

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.

Partial-Load Employee

You are employed by the College on a Partial-Load basis in accordance with the terms of the Academic Collective Agreement.

Hospital

Hospital is defined as a legally operated institution which is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and provides such facilities under the supervision of a staff of doctors with a 24 hour a day nursing service by registered nurses.

Notwithstanding the above, hospital shall mean a legally operated

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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.

In no event will that part of an institution which operates as a home for the aged, rest home, nursing home, chronic care facility or a place for the care and treatment of drug addicts or alcoholics be considered a hospital for the purpose of this contract.

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, sickness or the consequences of surgery needed to donate a body part to another person.

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 10 for further details.

Section 4 - Categories of Benefits

Basic Benefit

All Partial-Load employees shall participate in the following benefit. However, if you have Extended Health Care coverage through your spouse's group insurance plan you may elect in writing to wave this coverage:

- Extended Health Care

Premiums

	College pays:	Employee pays:
Extended Health Care	100%	0%

Optional Benefits

You may elect to participate in the following benefits:

- Basic Life Insurance
- Accidental Death and Dismemberment Insurance
- Supplementary Life Insurance
- Employee Pay-All Life Insurance
- Dependent Life Insurance
- Vision Care (Must have elected Extended Health Care)
- Hearing Care (Must have elected Extended Health Care)
- Dental Care
- Critical Illness Insurance

Premiums

	College pays:	Employee pays:
Basic Life Insurance	0%	100%
AD & D Insurance	0%	100%
Supplementary Life Insurance	0%	100%
Employee Pay-All Life Insurance	0%	100%
Dependent Life Insurance	0%	100%
Vision Care	0%	100%
Hearing Care	0%	100%
Dental Care	0%	100%
Critical Illness Insurance	0%	100%


Premium Deductions

In addition to the cost of the benefits, if you are a resident of Ontario or a resident of Quebec, provincial 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.

Section 5 - When Coverage Begins

New Employee

The waiting period for a new employee under your group contract is indicated on the following chart. For purposes of your group insurance benefits, you are considered a new employee under your first partial-load contract or if there is a break of more than 6 months between partial-load contracts.

Benefit	Waiting Period
Basic Life Insurance Accidental Death & Dismemberment Insurance Supplementary Life Insurance Employee Pay-All Life Insurance Dependent Basic Life Insurance Extended Health Care (including Vision and Hearing Care)	First of the month following the completion of one calendar month of employment. <div style="text-align: center;">  </div>
Dental Care	First of the month following the completion of six calendar months of employment.
Critical Illness Insurance	The coverage becomes effective on the first of the month in which your application is approved by the insurance company.

Bridging Benefits and Waiting Period

If you were participating in a benefit and have completed your initial waiting period and you become re-employed with the College within 6 months of the end of any partial-load contract, waiting periods for these benefits will be waived and coverage will be effective from the first day of the new partial-load contract.

Optional benefits once declined are not available unless more than 6 months have expired between partial-load contracts. Where more than 6 months have expired between partial-load contracts, you will have to complete a new enrolment form and elect the coverage you wish. The appropriate waiting periods must be served on all the benefits you elect (see above table).

Coverage starts	Your coverage begins the first day following the completion of the waiting periods provided you are 'actively at work' 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'.
Actively at Work Provision	<p>You must be actively at work on the date you qualify for the insurance but if you are absent on that date, you will qualify on the day you return to active work.</p> <p>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.</p> <p>In the event benefit improvements for Life Insurance are negotiated, you must be actively at work on the date improvements to the Life insurance are effective in order to qualify for such improvements. If you are absent on that date, you will qualify on the date you return to active work.</p>
Dependent(s)	<p>Coverage for your Dependents begins on the latest of:</p> <ul style="list-style-type: none">■ 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 6 - Enrolment

Enrolment Form	<p>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.</p> <p>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 important that you read this form, fully answer the questions, and return it to your Benefits Administrator no later than 31 days after you become eligible for the coverage without jeopardizing</p>
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your entitlement to coverage.

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

You will be enrolled in the benefits you have elected upon the 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 Sun Life to process your claims and for you to access your claims information.

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.

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 date you acquire a Dependent or an additional Dependent

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's Benefits Administrator.

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 will be required to continue to submit proof of good health to Sun Life, and depending on your individual situation, 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 when the change occurs or when Sun Life approves proof of good health, the change cannot take effect before you return to active work.
- if a Dependent, other than a newborn child, is hospitalized on the date when the change occurs, the change in the Dependent's coverage cannot take effect before the Dependent is discharged from hospital.

Section 8 - Bridging Group Insurance Benefits

What is Bridging?

Bridging refers to your entitlement to maintain benefit coverage between your current partial-load contract and re-employment under a subsequent partial-load contract.

What happens to my benefits during the

You may continue the benefits at the end of your contract:

- until your next contract if you have a written contract of future

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bridging period?

- partial-load employment, or
- if you have been granted a leave of absence by the College as per Articles 12, 21, 22, 23 of the Collective Agreement for a maximum period of 24 consecutive months.

Who pays the premium?

If you pay 100% of premiums, benefits will continue.

How are the waiting periods affected?

There is no waiting period on benefits that you have bridged or if you are rehired within six months as a partial-load employee.

A waiting period is applicable again if more than 6 months has elapsed between partial-load contracts.

Section 9 – Termination of Coverage

When coverage ends
For Active Employees

Benefit 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 Supplemental Life, Employee Pay-All Life and Dependent Life, the end of the month in which you attain age 65, but no later than August 31st following your 65th birthday if you are actively at work.
- for Critical Illness, see Section 19.

Refer to Section 18 for details about converting your Life Insurance.

For Dependent(s) of Active Employees

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

- the end of the month in 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. For Survivor Benefits see Section 10.

Bridging Benefit

Please refer to the bridging benefit provisions under Appendix V of the Academic Collective Agreement and Section 8 of this booklet.

Coverage after Retirement

If you retire, you may be eligible to continue certain benefits. Please request information from your Benefits Plan Administrator or refer to the Council's website at www.thecouncil.on.ca for an explanation of the benefits available to retiring employees.

Section 10 - Survivor Benefits

Survivor Benefits For Dependent(s) of Active Employees

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

- the last day of the sixth month following the month in which you die, unless the survivor elects to continue the coverage.
- the date the benefit provision under which the Dependent is covered terminates.
- the end of the period for which premiums have been paid.
- 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 eligible survivor may elect to continue Extended Health Care, Dental Care, Vision and Hearing Care. The College pays the full premium for the first six months for the Extended Health Care coverage. Beyond six months, the eligible survivor will be required to pay the full premium for the Extended Health Care coverage. The eligible survivor may elect to continue the Vision, Hearing and Dental Care coverage, and is required to pay the College quarterly, in advance, the full cost of the Plans.

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

Thereafter, the eligible survivor who is in receipt of a lifetime monthly survivor pension, may elect to participate in retirement benefits provided such election is made within 31 days from the end of the month you would have reached age 65 and the eligible survivor continues to be eligible for benefits under OHIP or another Canadian medicare plan equivalent to OHIP from another province or territory.

The eligible survivor will keep the College informed of any change in address or other information as the College or the insurer may require. 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.

- their date of birth.
- their Social Insurance Number.

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 (e.g. OHIP). 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 you must be a Canadian resident and entitled to coverage under OHIP, (see also Section 14) or another Medicare plan equivalent to OHIP from another Canadian province or territory or Canadian federal government plan.

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 Partial-Load Academic employees who have completed the enrolment form electing the benefit and served the waiting period are covered by the Extended Health Care Plan which includes semi-private hospital accommodation. Current employees who had elected to remain in Plan II (excludes coverage for semi-private hospital accommodation) and some Out-of-Canada expenses) have been grandparented. All new employees have access only to Plan I on completion of the waiting period.

Waiting Period

Completion of one calendar month of employment. The coverage begins on the first day of the month 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 each 2 Benefit Years for persons 18 years of age and older.
Note: Vision Care maximum increased to \$400.00 effective January 1, 2008.

- 100% of eligible expenses for Hearing Care to a maximum of \$3,000 in each 3 Benefit Year 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 should contact Sun Life to ensure that you are eligible to claim the purchase.

85% of eligible expenses for:

- hospital confinement outside Canada for room and board and other hospital services (excluding any room and board charge above the Hospital's semi-private rate).
- hospital out-patient services provided outside Canada for treatment of an illness contracted outside Canada.
- services, while not confined to a Hospital, of private duty registered nurses or registered trained attendants.
- prescription drugs.
- medical services.
- services of physicians and surgeons outside Canada for emergency health services, subject to the medical fee schedule of the person's Province of residence.
- dental services required as the result of an accident.
- paramedical services.

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 employment with the College.

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 pay 85% of the following costs while you are temporarily outside Canada:

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- 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 (see the illustration of doctor's charges in Section 15).

Because this is not travel insurance, it is recommended that you purchase additional travel insurance.

Prescription Drugs

Please note that doctors occasionally prescribe drugs which may be readily available over the counter. These drugs 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 that are prescribed in writing by a doctor or dentist and are obtained from a pharmacist.

- 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 or a dentist and are obtained from a pharmacist.
- over-the-counter 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:

- hair growth stimulants.
- products to help you quit smoking.
- 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 to encourage weight loss, including drugs, proteins and food or dietary supplements.
- cough medicines.
- baby food and formula.
- minerals, proteins and vitamins.

Other health professionals allowed to prescribe drugs

The Plan will 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.

Medical services Reimbursement Amount

The Extended Health Care 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

- 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, 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 if the required services cannot be performed by anyone with lesser qualification.

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. 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.

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

Dental Services as the result of an accident

- 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 to Sun Life a separate detailed account of the cause of the injury along with the Extended Health Care claim form.

Medical Supplies and Equipment

- iron lungs, wheelchairs, or other durable equipment rented for temporary therapeutic use. It is important to note that where the purchase of durable equipment is less expensive than rental, it will be given consideration by Sun Life.
- 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.
- oxygen and its administration.

Note: Coverage may be co-ordinated with the Assistive Devices Program administered by the Province. Further information is provided under Section 14.

Orthopaedic Shoes

- orthopaedic shoes, up to a maximum of 2 pairs for persons under 8 years of age, and one pair for persons 8 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. However, under the CAAT health plan orthopaedic shoes and orthotics are a combined maximum as noted above. i.e. you are eligible for either orthopaedic shoes or orthotics, not both, in each calendar year. 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

In any Calendar Year, the Plan will cover 85% of the costs, up to a combined maximum of \$1,500, for the licensed paramedical specialists listed below, per person.

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:
Services of licensed osteopath*, chiropractor*, chiropodist*, podiatrist*, naturopath, massage therapist, speech therapist, physiotherapist, audiologist, optometrist/ophthalmologist, occupational therapist, psychologist and acupuncturists.

*includes one x-ray examination per specialty each Calendar Year
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What is not covered

The Plan will not pay for the costs of:

- services or supplies not included in the list of eligible expenses as noted above.
- 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 correction surgery must be performed by an ophthalmologist and 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-year Benefit 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 person under age 18 years of age and every 2 years for all other persons.

The maximum benefit is increased to \$400 effective January 1, 2008.

[Persons under 18 years of age: The increase is effective January 1, 2008 which is in the September 1, 2007 to August 31, 2008 Benefit Year.

Persons 18 years of age and older: The increase is effective January 1, 2008, which is in the September 1, 2006 to August 31, 2008 two-year Benefit period.]

The Plan will not pay for glasses of any kind purchased over the counter.

PVS – Preferred Vision Services Inc.

Sun Life offers a Preferred Vision Care (*PVS*) program that may achieve savings. We encourage you to comparative shop before selecting PVS. PVS Cards can be obtained from the College Benefits Administrator.

Section 13 - Hearing Care

Hearing Care

The Plan will cover hearing aids, including maintenance and repairs, initially prescribed in writing by an ear, nose and throat specialist, 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.

In addition to the more usual hearing aid devices, coverage will also include expenses for aids to hearing if prescribed by a medical doctor. These will include:

1. a device that produces extra-loud audible signals such as a bell, horn, or buzzer;
2. a device to permit the volume adjustment of telephone equipment above normal levels;
3. a bone-conduction telephone receiver; and
4. the batteries that are required for that purpose, and repairs.;
5. teletypewriter or similar device, including a telephone ringing indicator, that enables an individual to make and receive telephone calls;
6. a device to decode special television signals to permit the script of a program to be visually displayed; and
7. a visual or vibratory signaling device, including a visual fire alarm indicator, for an individual with a hearing impairment.

These expenses will be subject to the current \$3,000 maximum and time frame limitation.

The above coverage will be subject to the \$3,000 maximum per insured person as noted above.

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 or Hearing care under another plan, your benefits will be co-ordinated with the other plan following insurance industry standards. "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 Ontario 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 service 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 by the provincial plan for any eligible expenses or services up to the 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. For example you may be away on vacation, Professional Development Leave, an exchange programme, or going to school.

Emergency Health Services Any reasonable medical services or supplies, including advice, treatment, medical procedure 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 a portion of the cost of semi-private hospital room accommodations, out-patient services in a hospital and the services of 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. Please see the following examples.

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 the country you should review your Extended Health Care Plan and your personal needs in order to determine your requirements for an additional out-of-Canada plan.

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

Special Note:

If you lose provincial coverage 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 the claim is processed.

Hospital:

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

- 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, over
- the amount payable by OHIP.

The following is an example of what the Plan will pay or you may be required to pay provided you have semi-private hospital accommodation:

**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 1.5
- All figures in Canadian dollars

EHC Plan I

■ Full Bill (including Private Room)	\$7,470
■ Semi-private to private differential	-\$270
■ Net Bill	\$7,200
■ OHIP payment (4 x \$400)	<u>-\$1,600</u>
■ Balance	\$5,600
■ Sun Life Payment (85%)	<u>-\$4,760</u>
■ Balance	\$840
■ Semi-private to private room differential	<u>+\$270</u>
■ You would be required to pay	\$1,110
	or \$277.50 per day

For Plan II members, using the above example, no semi-private coverage would be available and your out-of-pocket expenses could be 5 times as great.

Doctors

Doctors services when rendered outside of Canada are covered under Plan I and II with the amount payable equalling 85% of the excess of the bill over the OHIP allowance, provided that excess 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. The following example is

provided to illustrate the out-of-pocket expenses you could incur.

Example

Appendectomy - Miami	
U.C.R. Charge*	\$2,000.00 (US)
Charge at 1.5	\$3,000.00 (Canadian)
OHIP Payment	\$233.50
Amount Outstanding	\$2,766.50
OMA Fee Schedule	\$377.84
Sun Life Payment (85% of OMA amount)	\$321.16
You would be required to pay	\$2,445.34 (Canadian)

**U.C.R. Charge*

Usual, customary, reasonable charge.

Ambulances:

Both Plans I and II cover 85% of the cost (after OHIP) of out-of-Canada local ambulance service which generally means emergency transportation to or from the nearest hospital qualified to provide the required care.

The cost of airfare home from out-of-Province/out-of-Canada 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 is 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 and C Basic Services, including dentures	100%	\$2,500 each calendar year for Types A, B and C combined
Type E Crowns & Bridges	50%	\$2,500 each calendar year
Type D Orthodontic	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. The specific Ontario Dental Association procedure codes for the services described below are referenced in the Academic Collective Agreement and are subject to change from year to year.

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 – 100%)

Your dental benefits cover procedures used to help prevent dental problems including:

Oral examinations

- initial examination every 24 months.
- 1 recall examination every 5 months, up to a maximum of 2 examinations per calendar year.
- emergency or specific examinations.
- preventive recall packages.

X-rays

- 1 complete series of x-rays or 1 panorex every 24 months.
- 1 set of bitewing x-rays every 6 months, up to a maximum of 2 sets per calendar year.
- X-rays to diagnose a symptom or examine progress of a particular course of treatment.

Other services

- Required consultations with another dentist, excluding those for orthodontic purposes.
- Required consultations between the patient and dentist, excluding those for orthodontic purposes.
- Fillings – amalgam, silicate, composite, acrylic or equivalent.
- Polishing (cleaning) and topical fluoride treatment, once every 6 months, up to a maximum of 2 per calendar year.
- Protective athletic appliance (mouthguards).
- Scaling.
- Other preventive services.
- Diagnostic tests and laboratory examinations, but 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 – 100%)

Your dental benefits include procedures used to treat basic dental problems and include:

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, transplants and repositioning of the jaw.
- Therapeutic intra-muscular or intravenous drug injection.
- Adjunctive general services.

**Prosthodontic
Dental Procedures**
(Type C – 100%)

Your dental benefits include removable dental prosthesis to resolve dental problems and include:

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

Removable partial dentures - once every 3 years.

Denture adjustments.

Repair of dentures.

Rebase or reline of an existing partial or complete denture.

Customary commercial laboratory fees associated with the above.

Crowns and Bridges
(Type E – 50%)

Your dental benefits include permanent dental prosthesis to resolve dental problems and include:

Bridges.

Repairs to bridges.

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.]

Inlays.

Onlays.

Pins in inlays, onlays and crowns.

Post and core.

Replacement of dentures and bridges

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 its predecessor except where:

- 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, or
- 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 – 50%)**

Your dental benefits include procedures used to treat misaligned and crooked teeth and include:

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

Orthodontic procedures.

Diagnostic services - orthodontic cast.

Required consultations between patient and dentist.

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

Laboratory Fees

- Certain procedures will usually involve the cost of a commercial laboratory and when appropriate, a reasonable and customary laboratory fee will be reimbursed 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.

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 the eligible procedure.

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 dentures that are lost, misplaced or stolen.
- charges for appointments that you do not keep.
- charges for completing claim forms.
- expenses related to services or supplies of the type normally intended for home use.

Dental expenses 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 insured person.
- any cause for which compensation is available under the Workplace Safety and Insurance Act, Criminal Injuries Compensation Act or similar legislation.

Expenses Outside of Province/Canada

Expenses for emergency dental care outside 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 an other than 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 and financial liability for this benefit. Questions or inquiries in regard to this benefit must be directed to your College Benefits Administrator.

The Short Term Disability Plan (STD) is not an insurance plan. It is a benefit paid directly to you by the College. The full description of the STD Plan is set out in Article 17, 21.07 D and 26.08 of the current Academic Collective Agreement.

Cumulative Sick Leave Credits

A member of the Academic Bargaining Unit employed by the College on a Partial-Load basis on or after April 1, 1991, will accumulate sick leave credits in hours as set out in Article 26.08 B of the current Academic Collective Agreement.

Unused sick leave credits will be accumulated. However, no gratuity entitlement will be attached to these credits.

A member of the Academic Bargaining Unit employed by the College on a Partial-Load basis prior to April 1, 1991, will accumulate sick leave credits as set out in Article 26.08 B of the current Academic Collective Agreement.

Unused sick leave credits will be accumulated. After ten years of service at a single College, any unused sick leave credits are payable upon death, termination or retirement. The formula for calculating payment is:

$$\frac{\text{credits in hours}}{2} \quad X \quad \frac{\text{hourly rate of pay}}{480^*}$$

*Annual teaching maximum.

The payout is subject to a maximum gratuity of 50% of the annual maximum number of hours of teaching (i.e. 10 months X 4 weeks X 12 hours)

Sick Leave Plan

There is a bridging provision allowed for a partial-load employee who:

- is rehired within 6 months of the end of any contract;
- if upon termination of a contract has a written contract for future employment as a partial-load employee; or
- is on an approved leave of absence.

Section 18 - Life Insurance Coverage

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

You may elect to enrol in the Employee Life Insurance benefit. It is term insurance that covers you 24 hours per day while you continue to meet the eligibility requirements for insurance under the group contract. There are three levels of coverage. They are described below.

Basic Life Insurance If you have elected this insurance you have coverage in the amount of \$25,000.

Supplementary Life Insurance You may choose additional coverage in units of \$10,000 up to a maximum of \$60,000.

Employee Pay-All Life Insurance Provided you have chosen the maximum of \$60,000 under the Supplementary Life Insurance benefit you may choose to be covered in units of \$10,000 up to an additional \$140,000 under the Employee Pay-All Life Insurance.

If you are covered for the maximum benefits available under the Plan you would be insured for a total of \$225,000.

**Coverage during total
disability**

If you become totally disabled while insured your Life coverage will be continued until the end of the month in which you reach age 65.

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

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 left 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.

Accidental Death and Dismemberment

General description of the coverage
(Mandatory only if you elect Basic Life Insurance)

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.

Your Accidental Death and Dismemberment Insurance

Amount of Insurance - \$25,000

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 \$25,000. The percentage depends on the loss suffered. The following table shows the percentages used to determine the payment. However, only the largest percentage is paid for injuries to the same limb resulting from the same accident, and the maximum payable due to any one accident is \$25,000.

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 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%

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 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:
- suicide or self-inflicted injury, while sane or insane.
 - taking any poison, drug or medicine, whether voluntarily or otherwise.
 - inhaling gas, whether voluntarily or otherwise, other than as a result of performance by the employee of the regular duties of his employment.
 - bodily or mental infirmity or disease of any kind or infection other than infection occurring simultaneously with and in consequence of an accidental cut or wound.
 - 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.
 - war, insurrection or the hostile action of the armed forces of any country.

Coverage during total disability

If you became totally disabled while insured, your Accidental Death and Dismemberment coverage will be continued until the end of the month in which you reach age 65.

Dependent Life Insurance Coverage

General description of the coverage <i>(Optional)</i>	Dependent Life Insurance is term insurance which covers your spouse and dependent children while you remain an employee of the College and they continue to meet the eligibility requirements for the insurance.
<i>Amount of Insurance</i>	Spouse: \$5,000 Each child: \$2,000 The benefit is payable to you. Its purpose is to assist you and your family with the additional financial burden should your spouse or dependent children die.
<i>Coverage during Total Disability</i>	If you became totally disabled while insured, your Dependent Life coverage will be continued until the end of the month in which you reach age 65. 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 as beneficiary of your choice, a person, persons or your estate. In the event of your death, benefits will be paid in the name of the last legally nominated beneficiary you left on file with the College Benefits Administrator. 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 contains 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 the College Benefits Administrator.

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, and Accidental Death and Dismemberment coverage to an individual Life policy with Sun Life without providing proof of good health.

It is your responsibility to initiate an application to convert your Life Insurance with Sun Life. 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 may only exercise the conversion option once.

How much can I convert

You may convert your total Life Insurance coverage to a maximum of \$200,000.

How long do I have to convert my insurance?

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 conversion amount of Life Insurance coverage will be paid to your last named beneficiary as recorded on your file in the Human Resources Department as a death claim.

Converting your Dependent Life Insurance

When your Dependent Life Insurance coverage ends, you may apply to convert your spouse's Life coverage to an individual Life policy with Sun Life without providing proof of good health. This is not available for dependent children.

How long do I have to convert my spouse's life insurance?

You have 31 days from the date your Dependent Life insurance ceases to convert to a private policy with Sun Life.

What happens if my spouse dies during the conversion period?

If your Spouse dies during this 31 day conversion period, the conversion amount of Dependent Life Insurance coverage will be paid as a death claim to you.

Section 19 – Critical Illness Insurance

General description of Coverage	Critical Illness insurance provides protection that Long Term Disability, Life Insurance, and Extended Health Care insurance coverages do not. Following the diagnosis of a critical illness and a prescribed survival period, this insurance pays a one-time, lump-sum benefit. The benefit payment is not based on your inability to work or whether or not your expenses are medically-related. You collect the full amount even if you make a full recovery and you can use the money any way you want – to seek other treatment, purchase specialized equipment, pay your mortgage, or invest for your future.
Eligibility	You are eligible to apply for coverage provided you are a Partial-Load Academic employee of the Colleges of Applied Arts and Technology. To qualify, you must: <ul style="list-style-type: none">• be under age 60• reside in Canada• be actively at work• provide proof of good health
Coverage Effective Date	Your coverage becomes effective on the first of the month in which Sun Life Assurance Company of Canada approves your application. You will receive a certificate of insurance, outlining the details of your plan once your application is approved.
Insured Critical Illness Conditions	The Colleges of Applied Arts and Technology Critical Illness insurance plan covers a broad range of conditions – 10 in total – as follows: <ol style="list-style-type: none">1. Heart Attack (Myocardial Infarction)2. Stroke3. Cancer4. Coronary Artery Bypass Surgery5. Kidney Failure6. Paralysis7. Major Organ Transplant8. Multiple Sclerosis

9. Blindness
10. Deafness

For further description of these disabilities please ask your College Benefit Administrator for the “Critical Illness Insurance” brochure.

Limitations and Exclusions

No benefits are payable for claims resulting from:

- Declared or undeclared war, insurrection or rebellion
- Voluntary participation in a riot or act of civil disobedience
- Attempted suicide, or intentionally self-inflicted injuries while sane or self-inflicted injuries while insane
- Committing or attempting to commit a criminal offence
- Use of illegal or illicit drugs or substances, misuse of drugs or alcohol
- Any symptom or medical problem leading to a diagnosis or surgery if that symptom or medical problem began or occurred before the first premium due date
- Any symptom or medical problem, leading to a diagnosis of cancer, which commenced within 90 days following the first premium due date
- Death during the required survival period

Termination

Insurance coverage will end on the earliest of:

- The first of the month following attainment of age 65
 - The date the group policy terminates
 - The premium due date, subject to the grace period, for non-payment of premium
 - The date you are no longer an employee of the Colleges of Applied Arts and Technology
 - The date you no longer reside in Canada
 - The date you request in writing that insurance coverage be terminated
 - The date any Critical Illness benefit is paid
-
- The date you are diagnosed with cancer if such diagnosis was made or initiated by any symptom or medical problem within 90 days of the effective date

- The date you die

How to Apply

To apply for coverage, you must complete an application form, including medical questionnaire which may be obtained from your College Benefits Administrator.

You send the completed application form directly to Sun Life at the following address for approval:

Sun Life Assurance Company of Canada
Association & Affinity Business
P.O. Box 4097, Station A
Toronto, ON M5W 2Z5

If you would like more information, or have any questions about this plan, please contact Sun Life's customer Service department toll-free at 1-800-669-7921 (or in the Toronto area call 416-408-7390).

Section 20 - Submission of Claims

Making an Extended Health Care Claim

Claims should be submitted to Sun Life on a regular basis as they are incurred.

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 provision.

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

If you are covered for Extended Health Care under this plan and you and or 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 who 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.

Contract No. 50832 & 50090 - Partial-Load Employees Submission of Claims

Ontario Assistive Devices Program

The Ontario Assistive Devices Program (ADP), run by the Ontario Ministry of Health, helps people who have long-term physical disabilities get needed equipment and supplies. To find out more about this program, contact the Assistive Devices Branch of the Ministry of Health.

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.

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

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.

Prescription Drug Claims

- Complete all sections of the claim form.
- Attach your receipts and any necessary medical information.
- Make a copy of the form and your receipts for future reference.
- Forward the claim to the Sun Life claims office at the appropriate address noted on the claim form.

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 physician. This letter should describe the nature of your disability or your Dependent's disability, a diagnosis, how these nursing services will improve/stabilize the claimant's condition and the length of time the services will be required.

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 claimant's condition and the length of time the supplies or equipment will be required.

Contract No. 50832 & 50090 - Partial-Load Employees Submission of Claims

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.

How do I make a claim for survivor's benefits?

If you are entitled to and have elected survivor benefits follow the process stated above. Your Social Insurance Number will be your Identification number, not the certificate number 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 must keep a copy for your records and/or later submission to Sun Life.

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 must keep a copy for your records and/or later submission to Sun Life.

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.

Making a Dental Claim

Claims should be submitted to Sun Life on a regular basis as they are incurred.

Time limits for filing a claim

Claims must be received by Sun Life within 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 a claim form can be obtained from your Benefits Administrator at the College.

If you are submitting the claim to Sun Life:

- 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.

If your Dentist is submitting the claim electronically:

- Your Dentist is required to complete the applicable sections of the claim form.
- You complete the applicable sections of the claim form and sign it.

Your Dentist electronically forwards the claim directly to Sun Life and the payment is generated immediately.

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.

Contract No. 50832 & 50090 - Partial-Load Employees Submission of Claims

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. 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 Benefits Administrator at the College.

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 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 physician or funeral home 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 six 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 physician or funeral home 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 makes every effort to keep the College Benefits Administrator informed of the status of the claim.

Making a Critical Illness Insurance Claim

How to make a claim Your College Benefits Administrator must be contacted immediately and will assist you with the process.

Time Limits for filing a claim Sun Life must receive notice of claim as soon as reasonably possible after the date of diagnosis or surgery. Sun Life will provide you with the appropriate claim forms on receipt of notice. Initial notice must be given no later than 30 days and proof of claim no later than 90 days from the date of diagnosis or surgery.

Failure to give notice of claim or furnish proof of claim within the above time limits does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of diagnosis or surgery if it is shown that it was not reasonably possible to give notice or furnish proof within the above time limits.

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 416-408-7390.
Sun Life's toll-free number is 1-800-669-7921.

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.

