



**University of Alberta**

# **Support Staff Bridge Benefit Program**

Coverage effective January 1, 2011

Updated August 2013



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## Introduction

The Support Staff Bridge Benefit Program is a Board/NASA negotiated benefit for eligible staff who retire from their employment with the University and start receiving a pension before age 65. This program provides a level of benefit coverage from retirement until age 65.

This booklet describes coverage under the program in effect on July 1, 2013.

This program is subject to future change. Written notices that you receive describing plan changes will supplement this booklet and should be retained for your reference.

If you have any questions about the information in this booklet please contact:

The University of Alberta Benefit Administrator  
780-492-4555  
benefits@ualberta.ca

or

NASA  
780-439-3181  
nasa@ualberta.ca

*The information in this booklet provides a summary of the Support Staff Bridge Benefit Program. If there are any discrepancies between the information in this booklet and the official plan documents, the official plan documents will prevail.*



# General Information

## Eligibility

This program provides coverage for eligible participants who retire from the University of Alberta and start receiving a pension before age 65.

To be eligible for this program, at the time you retire you must:

- be a full-time regular operating funded support staff
- be at least age 55
- have at least 20 years of University of Alberta pensionable service

Coverage under this program starts immediately after you retire and continues until the last day of the month in which you turn age 65. You must submit a copy of your Public Service Pension Plan pension payment confirmation letter within 90 days of your retirement for continued coverage.

## Plan Overview

The Support Staff Bridge Benefit Plan is fully paid by the employer and includes:

- Supplementary Health Care
- Dental Care
- Employee Family Assistance Program (EFAP)
- Basic Life Insurance

You also have the option to continue any optional life and voluntary accident insurance for yourself or your dependants that was in effect just before you retired. You pay the cost of this optional coverage.

## Eligible Dependants

Your eligible dependants include:

- your opposite or same sex spouse by marriage, or a partner with whom you have cohabitated for at least 12 months in a marriage-like relationship
- your children and your spouse/partner's children (other than foster children) who are under age 21 and are not married or in any formal union recognized by law
  - ◇ coverage continues until age 25 if your child is a full-time student at an accredited educational institution and dependent on you for financial support
  - ◇ coverage continues after age 21 if your child is incapable of financial self-support due to a physical or mental disability

Your dependants are eligible for coverage on the day that you become eligible, or on the day they become your eligible dependant, if later.

## Updating Your Records

In order to ensure that your coverage remains current, it is important that you advise the University Benefit Administrator of changes to your dependants, beneficiary, address, or banking information.



## General Information

### When Coverage Ends

Your coverage ends on the earliest of the following dates:

- the last day of the month in which you turn age 65
- upon your death
- the date that this plan terminates

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

- the date your coverage ends
- the date the dependant is no longer an eligible dependant

If you die while covered by this plan, coverage for your dependants will continue until the earlier of the following dates:

- the date that your bridge benefit coverage would have ended
- six months after the date of your death (the end of the month)
- the date your dependant child would no longer be considered your eligible dependant under this plan if you were still alive

### Part-time Staff Participation

Effective January 1, 2011, part-time regular operating funded support staff who retire from the University and start receiving a PSPP pension before age 65, and who meet the same age and PSPP service eligibility criteria as full-time employees, may participate in the bridge benefit health coverage (supplementary health care, dental care and the employee and family assistance program) at their cost. Continued basic and optional life and accident insurance coverage is not available to part-time staff.

A one time election to participate is available at the time of retirement. If coverage is elected, it will start immediately after retirement and cease the earlier of:

- the last day of the month in which you turn age 65
- the first day of the month for which premium payments have not been made (with no future right to opt back in)

### Coordination of Benefits

If your spouse/partner has coverage under another plan, you each submit claims to your own plan first. Any expenses that are not paid from your own plan can then be submitted to the other plan. If the claim is for a child, submit the claim first to the plan of the parent whose birthday occurs first in the calendar year.

The maximum amount that you can receive from all plans is 100% of actual eligible expenses. Be sure to include the Adjudicators Explanation of Benefits (EOB) from the first plan when submitting to the second plan.

If your spouse/partner has coverage under the Alberta Seniors Plan, submit all claims to that plan first. Any expenses that remain outstanding can then be submitted to this plan.

### Adjudicator for Supplementary Health Care and Dental Care Plans

An adjudicator is a third party independent of the University who shall determine the amount of benefits payable under all claims submitted to them and who provides claims payment and record keeping. Sun Life Financial is currently the adjudicator for the Supplementary Health Care and Dental Care plans.



# Supplementary Health Care

Supplementary Health Care coverage pays for eligible services or supplies that are medically necessary for the treatment of an illness, injury or chronic health condition. In this section, “you” means the plan participant (retired employee) and your eligible dependants. To qualify for this coverage, you must be entitled to benefits under a provincial health care plan, or federal government plan that provides similar benefits.

An expense must be claimed no later than 90 days following the end of the calendar year in which it was incurred. You incur an expense on the date the service is received or when supplies are purchased or rented.

## Definitions

The following definitions apply when these terms are used in this section:

<b>Accident</b>	A bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
<b>Appropriate Treatment</b>	Any treatment performed and prescribed by a doctor or a medical specialist that is the usual and reasonable treatment for the condition and provided as frequently as is usually required by the condition. It is not limited to examinations or testing.
<b>Convalescent Hospital</b>	A facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis with nursing and medical care 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.
<b>Doctor</b>	A physician or surgeon who is licensed to practice medicine where that practice is located.
<b>Emergency</b>	An acute illness or accidental injury that requires immediate medical treatment prescribed by a Doctor.
<b>Emergency Services</b>	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 which existed prior to the person leaving their province of residence.
<b>Experimental or Investigational Treatments</b>	Treatments that are not approved by Health Canada or other government regulatory body for the general public.



## Supplementary Health Care

<b>Hospital</b>	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.
<b>Illness</b>	An illness is a bodily injury, disease, mental infirmity or sickness.
<b>Medically Necessary</b>	Generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of an illness in accordance with Canadian medical standards.
<b>Reasonable and Customary Charges</b>	The fees within the usual range of charges made by others of similar standing in the area in which the charge is incurred when providing the same or comparable services or supplies.
<b>Year</b>	The calendar year January 1 to December 31

### Prescription Drugs

This plan covers **80%** of the cost of drugs that are only available when prescribed by a doctor or a dentist, and are obtained from a licensed pharmacist. Coverage is based on a least cost alternative (LCA) price basis and generic substitution of brand name drugs, unless your doctor has noted “no substitution” on the prescription. The plan covers quantities for a three-month period to be dispensed at one time.

The maximum coverage for a pharmacy dispensing fee is \$6.40 per prescription.

Prescription drug coverage also includes:

- diabetic supplies including insulin, syringes, test strips
- prescribed contraceptive devices, including intrauterine devices (IUDs) or the contraceptive patch
- vaccines and influenza shots, whether or not they require a prescription, plus the cost of administration of the injection
- injectable drugs
- varicose vein injections, including the cost of administration of the injection.
- over-the-counter medications, when prescribed by a doctor and approved by Sun Life as an accepted treatment for a chronic life-threatening illness
- medical marijuana, purchased from either Health Canada or a designated producer subject to the Marijuana Medical Access regulations and Section 56 of the Controlled Drug and Substances Act

This plan also covers certain drugs prescribed by other qualified health professionals in the same way as if the drugs were prescribed by a doctor or a dentist, if the applicable provincial legislation permits them to prescribe drugs.



## Supplementary Health Care

### Hospital Expenses in Canada

The plan covers **100%** of the difference between the cost of ward and a semi-private or private hospital room. It also covers the cost of room and board in a convalescent hospital if this care has been ordered by a doctor, as long as it is primarily for rehabilitation and not for custodial care. The maximum benefit payable is for 180 days for the treatment of an illness due to the same or related causes.

### Medical Services and Equipment

The plan covers **100%** of the reasonable and customary charges for the following medical services:

- Transportation in a licensed ground and/or air ambulance, if medically necessary, that takes you to 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 for emergency services.
- Out of hospital private duty nurse services when medically necessary and ordered by a doctor. Services must be for nursing care and not for custodial care. The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. Maximum coverage is \$25,000 per person during any three consecutive years.

The plan covers **80%** of the reasonable and customary charges for the following medical services and supplies:

- Hearing aids up to a maximum of \$1,600 per person per ear every five years. Repairs and audiologist exams are included in this maximum.
- In-patient and out-patient physician and hospital non-emergency medical treatment incurred out of province or out-of-Canada, to a maximum of \$4,000 per person per year.
- Casts, splints, trusses, braces or crutches.
- One pair of custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, per person in a year. Or two pairs of custom-made orthotic inserts for shoes when prescribed by a doctor, podiatrist or chiropodist up to a maximum of \$400 per pair per person in a year.
- Medically necessary equipment that is rented (or purchased at Sun Life's request). If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. Eligible equipment includes: wheelchair, hospital bed, iron lung, respirator, inhalers/inhalators, peak flow meter, CPAP monitor to a maximum of \$1,600 every five years, CPAP replacement supplies once every 12 months. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- Elastic support stockings, including pressure gradient hose, up to a maximum of two pairs per person in a year.
- Stump socks up to a maximum of five pairs per person in a year.
- Dental services 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.
- Artificial limbs and eyes.
- Radiotherapy and coagulotherapy.



## Supplementary Health Care

- Ileostomy, colostomy and ostomy supplies.
- Oxygen, plasma and blood transfusions.
- Laboratory tests, x-rays and ultrasounds rendered outside a hospital, except if the covered person's provincial plan prohibits payment of these expenses.

The plan covers **50%** of the reasonable and customary charges for the following medical supplies:

- insulin pump once every five years to a maximum of \$800.
- glucoscan or glucometer once every five years to a maximum of \$500.
- a TENS unit once every five years to a maximum of \$500.

### Paramedical Services

The plan covers **80%** of the reasonable and customary charges, up to a maximum of \$1,000 per person per specialty in a year, for the following licensed paramedical specialists:

- acupuncturist
- chiropractor
- massage therapist (MTAA, NHPC or RMTA designation is required)
- naturopath
- podiatrist or chiropodists (includes surgical procedures)
- physiotherapist
- speech therapist

A doctor's referral is not required.

The plan covers **80%** of the reasonable and customary charges, in excess of the provincial health insurance program, for registered midwife services, up to a maximum of \$2,000 per pregnancy.

The plan covers **80%** of the reasonable and customary charges for psycho-educational assessments prescribed by a psychologist or psychiatrist, to a maximum of \$200 per person per year.

### Vision Care

The plan covers **80%** of eligible expenses to a maximum of \$240 every 24 months (every 12 months if under age 18), July 1 to June 30.

Eligible expenses include:

- optometrist/ophthalmologist fees
- contact lenses and eyeglasses (frames and lens)
- laser eye correction surgery

Contact lenses or eyeglasses must be prescribed by an ophthalmologist or licensed optometrist or optician. Laser eye correction surgery must be performed by an ophthalmologist.

The plan will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.



# Supplementary Health Care

## What is Not Covered

The plan 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, unless explicitly listed as covered under this plan
- the costs of services or supplies that exceed the reasonable and usual rates for the location where they are provided
- services or supplies provided by a member of a participant's immediate family
- equipment that Sun Life considers ineligible (for example, orthopedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers)
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments
- services or supplies that do not qualify as medical expenses under the Income Tax Act
- services or supplies for which no charge would have been made in the absence of this coverage
- cosmetic surgery, unless the services are performed to correct deformities resulting from illness or to correct congenital defects that significantly interfere with function

This plan does 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
- participation in a criminal offence

## Making Claims

Claims must be submitted **no later than 90 days following the end of the calendar year in which the claim was incurred** to be eligible for reimbursement.

Online claims submission continues to be available. You can access or sign up for online claims submission at [www.sunlife.ca/member](http://www.sunlife.ca/member). All plan members are encouraged to take advantage of this efficient and convenient method of submitting claims.

Paper claim forms are also available online from:

- Sun Life Plan Member Services, [www.sunlife.ca/member](http://www.sunlife.ca/member)
- University Benefit Administrator, [www.hrs.ualberta.ca/forms](http://www.hrs.ualberta.ca/forms)

Mail paper claims to:

Sun Life Assurance Company of Canada  
PO Box 2010 STN  
Waterloo, Ontario N2J 0A6

Claims history under the support staff employee supplementary health plan will be used to determine claims eligibility under this plan.

If you have questions regarding your claims or coverage, contact Sun Life at 1-800-361-6212.



## Supplementary Health Care

# Out of Canada Travel Benefit

### Emergency Coverage

Supplementary Health Care provides coverage for emergency medical expenses incurred while travelling outside Canada. Emergency coverage applies to medical emergencies that occur within 180 days of the date you leave Canada and is subject to a lifetime maximum of \$500,000 per person. An emergency means an acute illness or accidental injury that requires immediate medical treatment prescribed by a doctor.

The Travel Benefit covers:

- all services and supplies while in hospital
- outpatient and doctors' services
- transportation to the province where you live for medical treatment, as appropriate
- hotel accommodation and meals if you have been released from hospital and Europ Assistance determines you are not yet able to travel

Expenses for other eligible services or supplies are also covered when they are incurred outside the country where you live, subject to applicable limitations.

Europ Assistance is Sun Life's emergency travel assistance provider. At the time of an emergency, you or someone with you must contact Europ Assistance at the 24-hour operations center number listed on the Sun Life travel card (available at the Sun Life plan member services website). Give the customer service representative the information on your travel card and describe the situation. Give Europ Assistance your hospital, hotel or other current telephone number and stay in touch with them throughout the medical emergency until they confirm that you no longer need to do so.

All invasive and investigative procedures (including surgery, angiogram, MRI, PET scan, CAT scan) must be pre-authorized by Europ Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

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

Europ Assistance can

- refer you to physicians, pharmacists and medical facilities
- confirm your coverage and benefits
- facilitate payments to a hospital or medical provider, whenever possible
- monitor the medical situation if you are hospitalized



## Supplementary Health Care — Out of Canada Travel Benefit

Europ Assistance may determine with your attending physician, that you can be moved safely to a different hospital or treatment facility or be sent home. In this case they will guarantee and, if necessary, advance payment for transporting you.

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

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

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

### Emergency Services Excluded From Coverage

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

- services obtained more than 180 days after the date you left Canada
- any expenses exceeding the coverage limit of \$500,000
- 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 Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, if you refuse to go
- 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

### Liability of Sun Life or Europ Assistance

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

### Obtaining a Travel Card

A personalized Travel card can be obtained on the Sun Life plan member services website at [www.sunlife.ca/member](http://www.sunlife.ca/member).



# Dental Care

Dental Care coverage pays for eligible expenses for dental procedures provided by a licensed dentist, denturist, dental hygienist or anesthetist while covered under this plan. In this section, “you” means the plan participant (retired employee) and your eligible dependants.

Eligible expenses under this plan are based on Sun Life’s current year Alberta dental fee guide. If you live in another province in Canada, the plan covers eligible expenses based upon the fee stated in the Dental Association Fee Guide for a general practitioner in the province in which you live. Payments will be based on the current guide at the time the treatment is received.

When deciding what the plan will pay for a procedure, Sun Life will determine if other or alternate procedures could have been performed. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that a dentist would have performed. The plan will not pay more than the reasonable cost of the least expensive alternate procedure.

For an implant-related crown or prosthesis, the plan will pay the benefit that would have been payable under this plan for a tooth supported crown or a non-implant-related prosthesis. Sun Life will take into account any limitations that would have applied if there had been no implant. All other expenses related to implants, including surgery charges, are not covered.

If you receive any temporary dental service, it will be included as part of the final dental procedure used to correct the problem, and not as a separate procedure. The fee for the permanent service will be used to determine the usual and reasonable charge for the final dental service.

An expense must be claimed no later than 90 days following the end of the calendar year in which it was incurred. You incur an expense on the date your dentist performs a single appointment procedure. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

Before you start any major treatment or procedures that will cost more than \$500, you should have your dentist send an estimate to Sun Life, who will then advise you of the amount that is covered by the plan. This will ensure that you are aware of what your share of the payment will be before the treatment or procedure is done.

Dental Care references to a *year* refer to the calendar year, January 1 to December 31.



# Dental Care

## Basic Dental Coverage

The plan covers **80%** of eligible expenses for the following basic procedures that a dentist performs regularly to help maintain good dental health and prevent problems.

### *Oral Examinations*

You are covered for the following complete, recall or specific oral examinations:

- one examination in a year (if under age 16, two examinations in a year with a minimum of five months between examinations)

### *X-rays*

You are covered for the following x-rays:

- two bitewing films are covered once in a year (if under age 16, twice in a year with a minimum of five months between services)
- one complete series of x-rays or one panorex is covered in any two year period with a minimum of 24 months between the services

### *Cleaning, Fluoride and Oral Hygiene*

You are covered for cleaning and scaling of teeth, topical fluoride treatment and oral hygiene instructions:

- once in a year (if under age 16, twice in a year with a minimum of five months between services)

### *Pit and Fissure Sealants*

- This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Only persons under age 16 are eligible for coverage with one treatment covered per permanent molar tooth.

### *Space Maintainer*

- You are covered for this procedure when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth.

### *Fillings*

- You are covered for amalgam fillings (silver) and composite or acrylic fillings (white fillings).
- An amalgam filling procedure includes pulp cap, sedative base, local anesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing of the restoration. Multiple restoration on one surface will be considered a single filling.
- A composite or acrylic filling procedure includes pulp cap, sedative base, local anesthesia, occlusal adjustment, removal of decay or existing restoration, placement of filling and finishing of the restoration. Multiple restoration on one surface will be considered a single filling. Mesial-lingual, distal-lingual, medial-buccal and distal-buccal restorations on anterior teeth will be considered single surface restorations.
- You are covered for up to three retentive pins for amalgam and composite fillings per tooth.



## Dental Care

### *Endodontic Procedures*

Endodontic treatment is the treatment of disease of the pulp tissue.

The plan covers:

- root canal therapy (one standard treatment per tooth every five years)
- apexification (only for permanent teeth)
- apicoectomy
- retrofilling
- root amputation
- hemisection
- vital pulpotomy

### *Periodontic Procedures*

Periodontic treatment is the treatment of bone and gum disease.

The plan covers:

- scaling in excess of the scaling performed at the time of your annual examination to a combined maximum of eight time units of 15 minutes per person in a year
- periodontal surgery

### *Oral Surgery*

Oral surgery includes local anesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation.

The plan covers the following oral surgery procedures:

- extraction of erupted tooth – uncomplicated and complicated
- extraction of impacted tooth – soft tissue, partial bone and complete bone impaction
- extraction of residual root
- surgical exposure of impacted tooth
- alveoloplasty
- other procedures: stomatoplasty; remodeling mouth floor; vestibuloplasty; ridge reconstruction and mucus fold extension; surgical excision of tumors; surgical excision of cysts; surgical incision and drainage; surgical removal of foreign body; repairs of lacerations; frenectomy; salivary gland treatment; and antral surgery

You are covered for the following services only when you have eligible complicated oral surgery:

- anesthesia, including pre-anesthetic evaluation and post-anesthetic follow-up; general anesthesia; deep sedation; equipment and supplies. The anesthetic facility fee is not covered.
- conscious sedation: inhalation technique, intravenous sedation, intramuscular injections of sedative drugs and combined techniques of inhalation plus intravenous or intramuscular injections
- therapeutic injections: administration of intramuscular drug injections

### *Repairing, Relining or Rebased Dentures*

You are covered for repair of broken or damaged dentures and for one reline or one rebase of your dentures in any 12-month period. These services include six month follow-up care.



# Dental Care

## Major Dental Coverage

The plan covers **50%** of eligible expenses for the following procedures used to treat major dental problems:

### *Inlays, Onlays and Gold Foil Restorations*

Inlays and onlays are metal or porcelain fillings placed on the surface of the tooth. Inlays, onlays or gold foil restorations are covered only for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage. Replacement must be separated by at least five years.

Inlays are covered only when x-rays indicate a crown is required. Onlays are limited to teeth with extensive incisal or cusp damage.

### *Crowns*

Crown are covered only for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage. Replacements must be separated by at least five years.

### *Veneers*

Veneers are covered only for teeth that cannot be restored with a regular filling as long as they are not used primarily to improve appearance. Replacement must be separated by at least 36 months.

### *Dentures*

The plan covers:

- full dentures: you are covered for standard and standard immediate dentures; replacements must be separated by at least five years
- partial dentures; replacements must be separated by at least five years
- remake, partial denture; you are only covered when a replacement partial denture would be covered
- denture adjustments; this is included in the six-month follow-up care provided under both full and partial denture coverage
- tissue conditioning

### *Fixed Bridges*

The plan covers:

- initial bridges
- replacement bridges, if the existing bridges are at least five years old
- repair of fixed bridges
- re-cementing of fixed bridges

The plan will only pay for the least expensive procedure when considering the cost of a bridge.



## Dental Care

### What is Not Covered

The plan will not pay for services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program unless explicitly listed as covered under this benefit. The plan will only pay for a procedure that, in Sun Life's opinion, has a reasonably favorable prognosis.

The plan will not pay for:

- procedures performed primarily to improve appearance
- replacement of lost, misplaced or stolen dental appliances
- charges for appointments that you do not keep
- services provided by a member of a participant's immediate family
- charges for completing claim forms
- services or supplies for which no charge would have been made in the absence of this coverage
- supplies usually intended for sport or home use (for example, mouth-guards, sleep apnea appliance)
- charges related to temporomandibular joint (TMJ) treatment, except as otherwise indicated in the list of covered expenses
- charges related to procedures used to treat misaligned or crooked teeth (orthodontic treatment)
- transplants and repositioning of the jaw
- experimental treatments
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet), including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).

The plan will also not pay for dental work resulting from:

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

### Making Claims

Claims must be submitted **no later than 90 days following the end of the calendar year in which the claim was incurred** to be eligible for reimbursement.

Online claims submission continues to be available. You can access or sign up for online claims submission at [www.sunlife.ca/member](http://www.sunlife.ca/member). All plan members are encouraged to take advantage of this efficient and convenient method of submitting claims.

Paper claim forms are also available online from:

- Sun Life Plan Member Services, [www.sunlife.ca/member](http://www.sunlife.ca/member)
- University Benefit Administrator, [www.hrs.ualberta.ca/forms](http://www.hrs.ualberta.ca/forms)

Mail paper claims to:

Sun Life Assurance Company of Canada  
PO Box 2010 STN, Waterloo, Ontario N2J 0A6

Claims history under the support staff employee dental plan will be used to determine claims eligibility under this plan.

If you have questions regarding your claims or coverage, contact Sun Life at 1-800-361-6212.



# Employee and Family Assistance Program

The Employee and Family Assistance Program provided through Homewood Human Solutions offers psychological counseling, along with a wide range of wellness and life services.

The University of Alberta EFAP has been designed to:

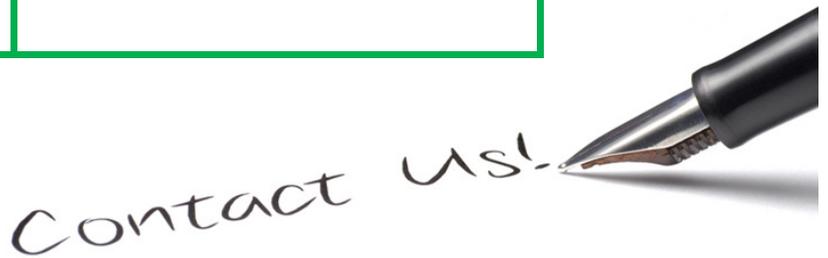
- provide immediate assistance in times of crisis
- provide support and advice for achieving your health goals
- help you tackle everyday life issues
- prevent problems from becoming overwhelming
- help you deal with depression, anxiety, fear, addictions or other personal health issues
- support you through life stage transitions (e.g. career change, blended family challenges, planning your retirement, eldercare or care giving, bereavement, etc.)

Services provided through the EFAP are available to you and your eligible dependants at no cost. No matter where you may be living or travelling, psychological counseling and e-services are available 24 hours a day, 7 days a week. Multilingual or translator services can be arranged to better meet your counseling needs if appropriate.

In addition to confidential professional counseling, plan members and their eligible dependants have access to:

Lifestyle Services	Plan Smart Services
<ul style="list-style-type: none"><li>• nutritional consultation</li><li>• services of a personal trainer</li><li>• health and wellness resources</li><li>• e-learning courses</li><li>• smoking cessation</li><li>• 12 Weeks to Wellness program</li></ul>	<ul style="list-style-type: none"><li>• legal advisory service</li><li>• financial consultation</li><li>• elder and family care service</li><li>• retirement planning</li></ul>

Homewood Human Solutions has been providing EFAP services since 1979, and has been the University of Alberta's sole EFAP provider since 2004.



**780.428.7587**  
**Outside Edmonton**  
**1.800.265.8310**  
**[www.hrs.ualberta.ca/efap](http://www.hrs.ualberta.ca/efap)**



# Life Insurance

Your life insurance coverage provides a benefit for your beneficiary if you die. Your dependant life coverage provides a benefit to you if your dependants dies. Great West Life is the current life insurance coverage provider.

## Basic Life Coverage

Your basic life coverage amount is one times your annual salary in effect immediately before your retirement date, rounded to the next higher \$100. The minimum coverage amount is \$15,000. This coverage ends on the last day of the month in which you turn age 65.

## Optional Life and Accident Coverage

You have the option to continue any of the following optional insurance coverage that was in effect just before you retired:

- optional employee life insurance
- voluntary accident insurance
- dependant life insurance

Optional coverage ends on the last day of the month in which you turn age 65, or when you stop paying the monthly premiums, whichever occurs first.

## Making Claims

The University Benefit Administrator is available to provide assistance with life insurance claims.

## Converting Life Insurance Coverage

When your life insurance coverage ends, you can apply to convert the group life insurance coverage to an individual policy with the Great West Life without providing medical evidence of insurability. You must request conversion of your coverage within 31 days of the date your coverage ends.

You also have 31 days to apply to convert your dependant life insurance coverage for your spouse to an individual policy without providing evidence proof of good health. The conversion option is not available for life insurance for dependant children.

Contact the University Benefit Administrator for further details regarding conversion of your coverage.



