Sun Life Financial

your group benefits

Teck

Trail Union Employees Local 480

Contract Number 150039 and 151049
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Benefit Summary

This is a general summary of the coverage provided under your group plan and should be read together with the information contained in this booklet. For more information, including exclusions, limitations and other conditions, please refer to the appropriate sections of this booklet.

General Information

Waiting period	Dental Care benefit and Vision care coverage – the period ending on the last day of the month in which you have completed 6 months of continuous employment. Benefits coverage begin on the day following the waiting period. Healthy Lifestyle Account – the period ending on the last day of the month in which your employment began. However, if your employment began on the first day of the month, there is no waiting period. All other Extended Health Care coverage – no waiting period
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of your booklet.

Extended Health Care

Benefit year	January 1 to December 31
Deductible	$25 each benefit year for each person up to a maximum of $25 per family.
Reimbursement level	For all eligible expenses combined, the reimbursement levels described below apply to the first $1,000 of paid claims per person per benefit year. Thereafter, any eligible expenses in excess of $1,000 of paid claims per person per benefit year, are paid at 100%.
Prescription drugs	80%, after the deductible
Medical services and equipment	80%, after the deductible
Paramedical services	80%, after the deductible, up to the maximums listed under the paramedical services section

In-province hospital	100%, without the deductible, of the difference between the cost of a ward and a private hospital room
Chronic care hospital	100%, without the deductible, of the difference between the cost of a ward and a private room, up to a maximum of $10.50 per day per person
Out-of-province emergency services	100 %, after the deductible Emergency Travel Assistance included
Vision care (Includes eye examination)	100%, without the deductible, up to a maximum of $300 per person per 2 benefit years. If no amount was reimbursed for these expenses for the person in the two previous benefit years, the $300 may be carried over to a maximum benefit of $600. Services of an ophthalmologist or licensed optometrist are further limited to 1 examination per person over 2 benefit years.
Maximum benefit	Lifetime maximum benefit – $100,000 per person (including Out-of-Province emergency services).This maximum does not include expenses incurred while the person is travelling on business.
Termination	Last day of the month in which you retire or the date your employment ends. For more information about coverage after retirement, please contact your employer.

Dental Care

Benefit year	January 1 to December 31
Fee guide	The current fee guide for general practitioners in the province where the treatment is received
Reimbursement level	
Preventive procedures (Plan A)	100%
Basic procedures (Plan A)	100%
Major procedures (Plan B)	85%
Orthodontic procedures (Plan C)	100%

Lifetime maximum	Orthodontic procedures – $2,500 per person
Termination	Last day of the month in which you retire or the date your employment ends. For more information about coverage after retirement, please contact your employer.

Healthy Lifestyle Account (Personal Spending Account)

Benefit year	June 1 to May 31
Plan credits	$300 on the commencement of each benefit year
Prorating	If your coverage starts after the commencement of the benefit year, your plan credits are adjusted to the month in which you become eligible for this benefit
Coverage ends	The date your employment ends

General Information

About this booklet

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

If your group benefits are modified after the effective date of this booklet in accordance with Collective Bargaining between the parties, you will receive written notification of changes to your group plan. The notification will supplement your group benefits booklet and should be kept in a safe place together with this booklet

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

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

In addition, the contract holder has established a Healthy Lifestyle Account (Personal Spending Account) and entered into a Personal Spending Account Services Contract with Sun Life. The contract holder has the sole legal and financial liability for the Healthy Lifestyle Account (Personal Spending Account) and Sun Life only acts as administrator.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are an employee represented by the United Steelworkers Local 480.

- you are actively working for your employer.
- you have completed the waiting period.

For the Dental Care benefit and Vision care coverage, the waiting period ends on the last day of the month in which you have completed 6 months of continuous employment. Benefits coverage begin on the day following the waiting period.

For the Healthy Lifestyle Account, the waiting period ends on the last day of the month in which your employment began. However, if your employment began on the first day of the month, there is no waiting period.

For all other Extended Health Care coverage, there is no waiting period

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

Who qualifies as your dependant

Your dependant must be your spouse or your child

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse for at least the last 12 months, is an eligible dependant. You can only cover one spouse at a time.

Your children and your spouse's children (other than foster children) and children for whom you or your spouse have been appointed the legal guardian are eligible dependants if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending a recognized educational institution is also considered an eligible dependant until the age of 25 as long as the child is not married or in any other formal union recognized by law, and is entirely dependent on you for financial

support.

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

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

Enrolment

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

If both you and your spouse are employed by Teck, you may both enrol for employee coverage under the Extended Health Care or Dental Care coverage, or one of you may be enrolled as the dependant of the other. You cannot be enrolled as both an employee and a dependant. Also, your children, if any, can only be covered by one of you.

When coverage begins

Your coverage begins on the date you become eligible for coverage.

Dependant coverage begins on the date your coverage begins or the date you first have an eligible dependant, whichever is later.

However, for a dependant, other than a newborn child, who is hospitalized, coverage will begin when the dependant is discharged from hospital.

Once you have dependant coverage, any subsequent dependants will be covered automatically.

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

Changes affecting your coverage

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

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

Updating your records

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

- change of dependants.
- change of beneficiary
- change of name.

When coverage ends

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

- the last day of the month in which you retire.
- the date your employment ends.
- the date the benefit provision under which you are covered terminates.

Your employer is entitled to continue coverage in certain circumstances. Please contact your employer for details.

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.

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this employee benefits booklet.

However, if you die while covered by this plan, coverage for your

dependants will continue until the earlier of the following dates:

- the date the person would no longer be considered your dependant if you were still alive.
- the date the person becomes covered for coverage under another group plan.
- the date the benefit provision under which the dependant is covered terminates.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You can print the claim form that is available on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

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

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

Coordination of benefits

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

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

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

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

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

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

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

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

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

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

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.
- the plan of the parent not having custody of the child.
- the plan of the spouse of the parent not having custody of the child.

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

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

Recovering overpayments

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

Definitions

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

Actively working Actively working means an employee is attending his or her usual place of employment with the employer or a participating employer in a multi-employer group, is performing all the normal and customary duties for a full working day or shift, or is on a paid vacation or statutory holiday or on a regular non-working day.

Coverage will also be continued under the following circumstances:

- maternity/parental leave, but not more than the period required under the relevant legislation.
- a leave of absence that includes benefit coverage, that has been approved by the employer.
- basic sick leave and Long-Term Disability.
- On modified duties or, on a return to work program and/or, on Worksafe BC benefits.

Doctor A doctor is a physician or surgeon who is licensed to practice medicine

where that practice is located.

We, our and us We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care
(Medicare Supplement)

General description of the coverage

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

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

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness. *Medically necessary* means generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.

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

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

The benefit year is from January 1 to December 31.

Deductible

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

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

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

If 2 or more members of your family suffer injuries in the same accident, only one individual deductible is applied in each benefit year

against all eligible expenses for those injuries.

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

Reimbursement level

For all eligible expenses combined, the reimbursement levels described below apply to the first $1,000 of paid claims per person per benefit year. Thereafter, any eligible expenses in excess of $1,000 of paid claims per person per benefit year, are paid at 100%.

Lifetime maximum benefit

Under Extended Health Care, the maximum amount we will pay for any person is $100,000(including Out-of-Province emergency services).This maximum does not include expenses incurred while the person is travelling on business.

Prescription drugs

After you pay the deductible, we will cover 80% of the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

The Company will provide employees with a drug card for the following expenses:

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- diabetic supplies.

Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period.

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

- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.

- hair growth stimulants.
- products to help you quit smoking.
- all contraceptives.
- drugs for the treatment of infertility.
- vaccines.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Drug substitution limit

Charges in excess of the lowest priced equivalent drug are not covered unless the doctor specifies in writing that no substitution for the prescribed drug may be made.

BC Fair PharmaCare drug insurance plan

You are required, as a condition of coverage, to take all reasonable steps to qualify and obtain the fullest extent of reimbursement available under BC Fair PharmaCare.

We will cover 80% of the above costs while you are satisfying the annual deductible under BC Fair PharmaCare.

Once you have satisfied the annual deductible under BC Fair Pharmacare, we will cover 80% of any subsequent claims for the balance of that calendar year where any portion has not been paid or is not payable by BC Fair PharmaCare.

Other health professionals allowed to prescribe drugs

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

Medical services and equipment

We will cover 80% of the costs after you pay the deductible for the medical services listed below when ordered by a doctor (the services of a licensed dentist does not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $10,000 per person per benefit year up to a lifetime maximum of $25,000.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.

- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.

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

- wigs required as a result of an illness, up to a lifetime maximum of $500 per person. Wigs do not require a doctor's order.

- medically necessary equipment rented, or purchased at our

request, that meets your basic medical needs. Repairs to purchased items are included. We will replace the item when it can no longer be made functional. We may request trade-in or return of replacement equipment. Reimbursement on rental equipment will be made monthly and will in no case exceed the total purchase price of similar equipment. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. 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.

- transcutaneous electrical nerve stimulation (TENS) machines, when prescribed for intractable pain.
- therapeutic electrical muscle stimulators (TEMS), when all muscle tone has been lost due to an illness.
- casts, splints, trusses, braces, crutches, walkers, collars, cane and tips.
- breast prostheses required as a result of surgery.
- surgical brassieres required as a result of surgery, up to a maximum of $150 per person in a benefit year.
- artificial larynx, limbs and eyes. For myoelectric limbs, eligible expenses are limited to the cost of a standard prosthesis.
- stump socks, up to a maximum of $200 per person in a benefit year.
- custom-made or prefabricated orthopaedic shoes or repairs and modifications, when prescribed by a doctor, chiropractor, podiatrist or chiropodist, up to a maximum of 4 pairs in a benefit year for a person under age 19 or 2 pairs per benefit year for any other person.
- hearing aids, up to a maximum of $300 per person over a period

of 5 benefit years for a person under age 22. Repairs are also included in this maximum. Batteries, charges and other accessories are not covered.

- oxygen, plasma and blood transfusions.
- colostomy supplies.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- insulin pumps, when self-administered injections by syringe or insulin pen are not feasible.
- speech processors, when prescribed for profound deafness, up to a maximum of $4,000 per person over a period of 5 benefit years.
- cardiac screeners.

Predetermination

We suggest that you send us an estimate before you obtain any Medical services and equipment that will cost more than $5,000. This way you will know how much of the cost you will be responsible for before you incur the expense.

Paramedical services

We will cover 80% of the costs after you pay the deductible, up to the maximums listed below for the following paramedical specialists. Paramedical services must be provided by a practitioner who is currently licensed, certified or registered to practice in the area where the service are provided.

- psychologists (testing excluded) or social workers, up to a maximum of $100 per person in a benefit year.
- massage therapists.
- physiotherapists.
- acupuncturists, up to a maximum of $100 per person in a benefit year.

- chiropractors and naturopaths combined, $300 each benefit year for each person up to a maximum of $750 per family per benefit year.
- podiatrists.

Hospital expenses in your province

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

We will cover out-patient services in a hospital and, the difference between the cost of a ward and a private hospital room, except for any services explicitly excluded under this benefit.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Chronic care hospital

We will cover the cost of room and board in a hospital for chronic care treatment.

If chronic care is provided in a hospital or a chronic care hospital including Riverview, Valleyview, Pearson and, UBC Health Science Centre, the maximum amount payable is the difference between the cost of a ward and a private room, up to a maximum of $10.50 per day per person. The deductible does not apply to these expenses.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. 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.

Emergency expenses out of your province

After you pay the deductible, we will cover 100% of the cost of the following emergency services while you are outside the province where you live:

- a hospital room at the ward rate, up to a maximum of 90 days. If, at the end of this period, your medical condition prevents you from returning to the province where you live, the 90 day limit will be extended.
- other hospital services provided outside of Canada. Other hospital services outside your province but within Canada are covered by the provincial medicare plan or federal government plan that provides similar benefits.
- out-patient services in a hospital.
- the services of a doctor.
- ambulance services.
- laboratory and x-ray services.
- prescription drugs in sufficient quantity to alleviate an acute medical condition.

Non emergency expenses

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

Emergency services

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

Emergency

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

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

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

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

Emergency services excluded from coverage

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

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.
- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Allianz Global Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any

complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.

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

Vision care

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

We will cover 100% of these costs up to a combined maximum of $300 per person per 2 benefit years.* If no amount was reimbursed for these expenses for the person in the previous 2 calendar year period, the $300 may be carried over to a maximum benefit of $600.
*The *2 benefit year* period is restarted for each person based on the employee's date of hire. The *2 benefit year* period for an employee who was hired in an even year will restart on January 1st of each even year. The *2 benefit year* period for an employee who was hired in an odd year will restart on January 1st of each odd year**.** Services of an ophthalmologist or licensed optometrist are further limited to 1 examination per person over 2 benefit years.

The deductible does not apply to vision care expenses.

We will not pay for sunglasses, unless they are prescription glasses needed for the correction of vision.

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

When coverage ends

Extended Health Care coverage will end on the last day of the month in which you retire or the date your employment ends. For more information about coverage after retirement, please contact your

employer.

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic 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. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integration with government

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

programs

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

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

- 365 days after the end of the benefit year you incurred the expenses, or
- 90 days after the end of your Extended Health Care coverage, whichever is earlier.

Claims may be submitted electronically for some expenses. Please contact your employer for more information.

Emergency Travel Assistance

General description of the coverage

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

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

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

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage.

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

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

Getting help

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

for all expenses related to that emergency.

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

Allianz Global Assistance may arrange for:

On the spot medical assistance

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

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

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

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

Transportation home or to a different medical facility

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

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

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

Repatriation

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

Legal assistance

If you require legal assistance, Allianz Global Assistance will locate an attorney for you and, if necessary, advance funds for bail and/or legal fees, where permitted by law, with satisfactory guarantee of reimbursement from you.

Lost documents

If your travel documents become lost or stolen while you are travelling outside of the province where you live, Allianz Global Assistance will direct you in how to arrange for replacement of travel documents. This is a service only. There is no benefit amount payable in the event of lost documents.

Coordination of coverage

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

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

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

Reimbursement of expenses

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

Allianz Globale Assistance coordinates with your provincial plan on

your behalf to ensure that your lifetime maximum is not used if other payment is available. Provincial plan claims guidelines are more restrictive than your current benefit program. We strongly recommend that you provide Sun Life with proof of the expenses within 30 days of returning to the province where you live. Your employer can provide you with the appropriate claim form.

Limits on Emergency Travel Assistance coverage

Allianz Global Assistance is committed to offering coverage in all countries, although political unrest or disaster situations may prevent them from offering full services. We recommend you review the Government of Canada Travel Advisory website to see if there are travel alerts issued for countries that may limit Allianz Global Assistance services during your trip.

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

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

Liability of Sun Life or Allianz Global Assistance

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

Dental Care

General description of the coverage

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

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

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

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

If services are provided by a board qualified specialist in endodontics, prosthodontics, oral surgery, periodontics, paedodontics or orthodontics whose dental practice is limited to that speciality, we will not cover more than the fee stated in the fee guide approved by the provincial Dental Association for that specialist or, if lower, 110% of the fee for general practitioners.

If the Dental Association does not publish a *fee guide* for a given year, Sun Life will continue to use the last published guide.

You are eligible for Major dental procedures (Plan B) when your dentist recommends replacement of your missing teeth, or reconstruction of your teeth (where basic restorative methods cannot be used satisfactorily).

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

determine the usual and reasonable charge for the final dental service.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date your dentist performs a single appointment procedure or an orthodontic procedure. However, if payment is made in advance for orthodontic procedures not yet completed, you will be considered to have incurred an expense on the date the advance payment is made. For other procedures which take more than one appointment, you incur an expense once the entire procedure is completed.

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Limitation on payments

We will only pay for 1 of the following procedures in any 5 year period when the same tooth is involved:

- inlay
- onlay
- crown
- veneer
- implant

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is $2,500.

Predetermination

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

Preventive dental procedures (Plan A)

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

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

Oral examinations

2 complete examinations per lifetime.

2 recall examinations per benefit year.

2 specific examinations per benefit year.

Emergency examinations.

X-rays

1 complete series of x-rays every 36 months.

1 panorex every 60 months.

2 sets of bitewing x-rays per benefit year.

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

Other services

Required consultations between two dentists.

Polishing (cleaning of teeth) and topical fluoride treatment, up to a maximum of 2 per benefit year.

Emergency or palliative services.

Diagnostic tests and laboratory examinations.

Removal of impacted teeth and related anaesthesia.

Provision of space maintainers for missing teeth.

Pit and fissure sealants, 1 treatment per tooth every 24 months.

4 Pulp vitality tests every 6 months.

1 diagnostic model per benefit year.

Required consultations between the dentist and the patient, limited to 4 units of 15 minutes per benefit year.

Basic dental procedures (Plan A)

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

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

Fillings Amalgam, composite, acrylic or equivalent. Amalgam, composite, acrylic or equivalent. You are covered for composite fillings to a maximum of 1 filling per surface per tooth per 24 months.

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

Basic restorations Prefabricated metal restorations and repairs to prefabricated metal restorations, other than in conjunction with the placement of permanent crowns.

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, including management of oral manifestations and oral mucosal disorders.

Scaling and root planing **Tartar removal.** Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

You are covered for up to 14 units of 15 minutes of tartar removal in a benefit year.

Occlusal adjustment and recontouring You are covered for 8 units of 15 minutes per benefit year.

Periodontal appliance Periodontal appliance, including bruxism appliance, up to a maximum of 2 appliances every 5 benefit years.

Gingival curettage Treatment of disease of the gum and other supporting tissue, including management of oral manifestations and oral mucosal disorders.

Oral surgery Surgery and related anaesthesia, other than the removal of impacted teeth (*Preventive dental procedures*) and implant related surgery

(*Major dental procedures*).

Inlays and onlays, subject to *Limitation on payments.*

Repair Repair of bridges or dentures.

Rebase or reline Rebase or reline of an existing partial or complete denture, including resilient liners in a relined or rebased denture.

Major dental procedures (Plan B)

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

We will pay 85% of the eligible expenses for these procedures.

Major restorations Crowns (including porcelain crowns on molars) and repairs to crowns, other than prefabricated metal restorations (*Basic dental procedures*).

Veneers Veneers are white facings put on the front of the tooth's surface. Veneers are only covered for teeth that cannot be restored with a regular filling as long as they are not used primarily to improve appearance.

Crowns, veneers and implants are subject to *Limitation on payments.*

Prosthodontics Construction and insertion of bridges, standard or precision dentures. Charges for a replacement bridge or replacement standard or precision denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge, standard or precision denture unless:

- it is needed to replace a bridge, standard or precision denture which has caused temporomandibular joint disturbances and which cannot be economically modified to correct the condition.
- it is needed to replace a transitional denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

Implants Implants, including surgery charges, subject to any limitations that would have applied under this plan to a tooth supported crown or a non

implant related prosthesis, respectively, if there had been no implant. The maximum amount payable is $2,200 per implant.

Orthodontic procedures (Plan C)

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

We will pay 100% of the eligible expenses up to the lifetime maximum for these procedures.

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

The following orthodontic procedures are covered:

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

When coverage ends

Dental Care coverage will end on the last day of the month in which you retire or the date your employment ends. For more information about coverage after retirement, please contact your employer.

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

What is not covered

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

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

We will not pay for:

- procedures performed primarily to improve appearance.
- the replacement of dental appliances that are lost, misplaced or

stolen.

- charges for appointments that you do not keep.
- charges for completing claim forms.
- services or supplies for which no charge would have been made in the absence of this coverage.
- supplies usually intended for sport or home use, for example, mouthguards.
- transplants, and repositioning of the jaw.
- charges related to the temporomandibular joint (TMJ) treatment.
- experimental treatments.

We will also not pay for dental work resulting from:

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

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca. The dentist will have to complete a section of the form.

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

- 365 days after the date you incur the expenses, or
- 90 days after the date the Dental Care coverage terminates under this contract, whichever is earlier.

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

Healthy Lifestyle Account (Personal Spending Account)

Administrator

This Personal Spending Account is administered by Sun Life Assurance Company of Canada.

General description of the coverage

The contract holder has established a Healthy Lifestyle Account and has the sole legal and financial liability for this Healthy Lifestyle Account under the Personal Spending Account Services Contract entered into with Sun Life. Sun Life only acts as administrator.

Your employer will be responsible for all payroll related deductions and issuing the appropriate tax information slips related to your Healthy Lifestyle Account.

Your Healthy Lifestyle Account coverage provides reimbursement to you for expenses described in this section under *Eligible expenses*.

An eligible expense is incurred on the date the expense is billed. Eligible expenses incurred by your dependant are also covered. Coverage applies only to eligible expenses incurred after the employee becomes covered under the Healthy Lifestyle Account and before the date the Healthy Lifestyle Account ends.

Your dependant must be your spouse or your child and a resident of Canada as described under *Who qualifies as your dependant* in the General Information section.

The benefit year is from June 1 to May 31.

How your Healthy Lifestyle Account works

Your Healthy Lifestyle Account works like an expense account. Your employer will allocate credits to your Healthy Lifestyle Account in the manner described under *Credits*.

Each time you submit a Healthy Lifestyle Account claim, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Healthy Lifestyle Account.

Balance carry-forward

This Healthy Lifestyle Account is set up with a ***balance carry-forward*** feature. This means that you may be reimbursed for eligible expenses incurred in a benefit year using credits received during that benefit year, as well as any unused credits that have been carried forward from the previous benefit year.

In other words, any credits remaining in your Healthy Lifestyle Account at the end of one benefit year will be carried forward and may be used to reimburse you for eligible expenses incurred in the following benefit year. Credits that are carried forward from one benefit year to the next will be lost at the end of the second benefit year if you have not used them by then. Carried forward credits are always used before new credits are used.

We must receive claims for eligible expenses incurred in a benefit year no later than 90 days after the end of the benefit year during which the eligible expenses are incurred, or 90 days after your Healthy Lifestyle Account coverage ends, whichever is earlier. Please see *When and how to make a claim*.

Continuation of coverage for dependants

No credits will be allocated to the Healthy Lifestyle Account after the employee's death. However, the remaining credits in the account on the date of the employee's death can be used to pay for expenses incurred by the dependants before the end of the benefit year during which the employee died.

Credits

$300 on the commencement of each benefit year.

If your coverage starts after the commencement of the benefit year, your plan credits are adjusted to the month in which you become eligible for this benefit

Eligible expenses

You can use your Healthy Lifestyle Account to help you pay for the following eligible expenses:

Fitness-related services

- fitness club memberships.

- registration fees for fitness-related programs or lessons, such as aerobic classes, yoga, dance lessons, figure skating and outdoor survival training.
- sports team memberships and registration fees.
- annual memberships, such as golf.
- court fees, green fees, ski passes, lift tickets and race registrations.
- personal trainers, fitness consultants, lifestyle consultants and exercise physiologists.

Fitness equipment

- durable equipment such as treadmills, exercise bikes and universal gym.
- skates, roller blades, bicycles, specialized athletic footwear, running shoes, tennis racquets, golf clubs, safety helmets and specialized sports equipment.

Health-related services

- weight management programs (excluding food).
- smoking cessation programs and supplies.
- costs for immunizations and travel medications.
- costs for medical examinations not covered by the provincial medicare plan.
- costs related to counseling on substance abuse.
- nutrition programs and counselling.
- maternity services (prenatal classes and mid-wife services).

- services for the following the paramedical specialists and alternative health practitioners: reflexologist, iridologist, herbalist, homeopath, athletic therapist, Chinese medical practitioner, Shiatsu therapist, osteopathic practitioner, acupressurist, speech therapist, psychologist, physiotherapist, acupuncturist, massage therapist, podiatrist, chiropodist, naturopath, chiropractor, osteopath, career coaches, audiologist, dietician, occupational therapist, optometrist and opthalmologist.
- stress management programs.
- cholesterol and hypertension screening.
- first aid and CPR (cardiopulmonary resuscitation) training.
- health assessments.
- allergy tests.
- vitamins and supplements, including herbal products.
- other alternative wellness services: Reiki, Ayurvedic medicine, touch therapy, Rolfing and light therapy.

When coverage ends

Health Spending Account coverage will end on the date your employment ends. Coverage may also end on an earlier date, as specified in *General Information*.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer or on our Sun Life Financial Plan Member Services website at www.mysunlife.ca.

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

- 90 days after the end of the benefit year during which the eligible expenses are incurred, or
- 90 days after the end of your Healthy Lifestyle Account coverage, whichever is earlier.

Respecting your privacy

At Sun Life Financial, 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 investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. 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.

You have a choice

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

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.