

your **group**
benefits

Teck

Trail Union Staff Local 9705

**Contract Number 100259, 150039 and 151049
Effective June 1, 2022**

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Benefit Details

In this section, you will find coverage details which are available to you as 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.

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.

For all other benefits – no waiting period.

Termination

Termination of coverage may vary from benefit to benefit as indicated in this Benefit Details. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Your Extended Health Care options
(including Teladoc Medical Experts services)

	Option 1 (Core)	Option 2
Benefit year	January 1 to December 31.	
Deductible	<p>For expenses other than, <i>Vision care, Hospital expenses in your province and out-of-province emergency and referred services:</i></p> <ul style="list-style-type: none"> ▪ Individual – \$500 per benefit year ▪ Family – \$500 per benefit year <p>For <i>out-of-province emergency and referred services:</i></p> <ul style="list-style-type: none"> ▪ Individual – \$25 per benefit year ▪ Family – \$25 per benefit year <p>This deductible ceases once the \$500 deductible for the above expenses has been satisfied</p>	<p>\$25 each benefit year for each person up to a maximum of \$25 per family</p>
Reimbursement level	<p>For all eligible expenses, the reimbursement levels are described below. However, under Option 2, 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%. This does not apply to expenses incurred for psychologists, social workers, or clinical counsellors.</p>	
Prescription drugs	100% after the deductible	80% after the deductible
Medical services and equipment	100% after the deductible	80% after the deductible
<i>Private duty nursing</i>	100%, after the deductible. \$10,000 per person per benefit year lifetime maximum of \$25,000	80%, after the deductible. \$10,000 per person per benefit year lifetime maximum of \$25,000

	Option 1 (Core)	Option 2
Paramedical services	100%, after the deductible, up to the maximum amounts indicated in the Extended Health Care section	80%, after the deductible, up to the maximum amounts indicated in the Extended Health Care section
Hospital expenses in your province	100% private room	100% private room
<i>Chronic care hospital</i>	100%, \$10.50 per day private room	100%, \$10.50 per day private room
Emergency services out of your province	Emergency – 100% after the deductible	Emergency – 100% after the deductible
Medi-Passport	Covered	Covered
Vision care <i>Maximum</i> <i>(Includes eye examination)</i>	100% \$300 per person per 2 benefit years* \$600 per person in a benefit year if no amount was reimbursed in the two previous benefit years	100% \$300 per person per 2 benefit years* \$600 per person in a benefit year if no amount was reimbursed in the two previous benefit years
	Services of an ophthalmologist or licensed optometrist are further limited to 1 examination per person over 2 benefit years.	
	*The 2 <i>benefit year</i> period is restarted for each person based on the employee’s date of hire. The 2 <i>benefit year</i> period for an employee who was hired in an even year will restart on January 1 st of each even year. The 2 <i>benefit year</i> period for an employee who was hired in an odd year will restart on January 1 st of each odd year.	
Changes in options	You can change your option during the annual enrolment period or within 31 days of a <i>life event change</i> .	
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 <i>General Information</i> .	
Overall maximum	All expenses, including out-of-province emergency services – lifetime maximum of \$100,000 per person The above maximums do not include expenses incurred while the person is travelling on business	

Your Dental Care options

	Option 1 (Core)	Option 2	Option 3
Benefit year	January 1 to December 31.		
Preventive (Plan A)	50%	70%	100%
Basic (Plan A)	50%	70%	100%
Major (Plan B)	50%	65%	85%
Implants	Not covered	Not covered	85% \$2,200 per implant
Orthodontics (Plan C)	Not covered	Not covered	100%
Lifetime maximum	N/A	N/A	\$2,600 for Orthodontics
Changes in options	You can change your option during the annual enrolment period or within 31 days of a <i>life event change</i> .		
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 <i>General Information</i> .		

Your Health Spending Account

Benefit year	January 1 to December 31
Plan credits	1/12 of the remaining Flex credits on the first day of each month of the benefit year
Coverage ends	Health Spending Account coverage will end when you retire. Coverage may also end on an earlier date, as specified in <i>General Information</i>

Healthy Lifestyle Account (Personal Spending Account)

Benefit year	June 1 to May 31
Plan credits	\$500 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	Healthy Lifestyle Account coverage will end on the date your employment ends. Coverage may also end on an earlier date, as specified in <i>General Information</i> .

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 contract 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 the following benefits:

- Extended Health Care
- Emergency Travel Assistance
- Dental Care
- Health Spending Account

This means Teck has the sole legal and financial liability for the benefits listed above 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.

All other benefits are insured by Sun Life.

Eligibility

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

- you are an eligible employee represented by the United Steelworkers of Workers, local 9705 located at Trail, B.C.
- you are actively working for your employer.
- you have completed the waiting period.

Waiting period

The waiting period is indicated in the *Benefit Details* section.

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 and a resident of Canada.

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 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.

In these cases, you must notify Sun Life within 31 days of the date the child attains the limiting age. Your employer can give you more information about this.

Enrolment

To enrol, you must request coverage in writing by supplying the appropriate enrolment information to your employer within 31 days after the date you become eligible. If your enrolment request is not received by your employer within the 31 day period, you will automatically be covered for the **Core (Option 1)** coverage. For a dependant to receive coverage, you must request dependant coverage.

If you or your dependants are covered for comparable Extended Health Care or Dental Care coverage under this or another group plan, you may refuse this coverage under this plan. If, at a later date, the other coverage ends, you can enrol for coverage under this plan at that time.

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.

Accessing your records

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

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

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

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

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

- our website at www.mysunlife.ca.

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

When coverage ends As 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 end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

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 under this plan 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.

Replacement coverage

The group contract will be interpreted and administered according to all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association concerning the continuation of insurance following contract termination and the replacement of group insurance.

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

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You 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.

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

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.

Life event change Life event changes include:

- marriage or any other formal union recognized by law, or common-law,
- birth or adoption of a child,
- divorce or legal separation,
- loss of spouse's benefit coverage, or
- death of a dependant.

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.

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

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.

Benefit year

The benefit year is indicated in the *Benefit Details* section.

Deductible

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

The deductible is indicated in the *Benefit Details* section.

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.

Lifetime maximum benefit

The lifetime maximum is indicated in the *Benefit Details* section.

Prescription drugs

We will cover 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 reimbursement level is indicated under each option in the *Benefit Details* section.

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

- drugs and oral contraceptives that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- intrauterine devices (IUDs) and diaphragms.
- 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.
 - vaccines.
 - drugs for the treatment of infertility.
 - products to help you quit smoking.
 - 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.

Reference Drug Program

The Reference Drug Program (RDP) applies to select drugs determined by Sun Life. Under RDP, Sun Life will:

- group together a set of drugs that are used to treat the same condition(s) in the same or similar way (a *therapeutic category*).
- determine the most cost-effective drug within a *therapeutic category* (the *Reference Drug*), considering such factors as cost to the plan, provincial programs, safety and clinical effectiveness.
- limit the eligible cost of drugs in a particular *therapeutic category* to the eligible cost of the *Reference Drug* (the *Reference Drug Limit*).
- apply the *Reference Drug Limit* to select province(s), excluding Québec. The selected province(s) may vary with each *therapeutic*

category.

For all *therapeutic categories*, the *Reference Drug Limit* applies to covered persons in the selected provinces having no previous claims for a *non-Reference Drug*. The *Reference Drug Limit* may also apply to covered persons with previous claims for a *non-Reference Drug* depending upon the *therapeutic category* and such factors as:

- clinical support for switching to the *Reference Drug*.
- expected duration of treatment.
- provincial programs.

Any claim submitted under this plan within 120 days before the date that Sun Life applies the *Reference Drug* to the plan is a previous claim. Any drug other than the *Reference Drug* in a *therapeutic category* is a *non-Reference Drug*.

When the *Reference Drug Limit* applies, charges in excess of this limit are not covered, unless there is a medical reason for the covered person to take the *non-Reference Drug*. To assess medical necessity, Sun Life will require the covered person and the attending doctor to complete and submit an exception form.

***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 up to the reimbursement level indicated under each option in the *Benefit Details* section 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 up to the reimbursement level indicated under each option in the *Benefit Details* section 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 the costs for the medical services listed below when ordered by a doctor (the services of a dentist do not require a doctor's order). The reimbursement level and the maximum amounts are indicated under each option in the *Benefit Details* section.

- 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. The maximum amount we will pay is indicated under each option in the *Benefit Details* section.
- 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 or injury.
- casts, splints, trusses, braces, crutches, walkers, collars, cane and cane 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 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 over a period of 5 benefit years for a child under age 17. Repairs, batteries, charges and

other accessories are not covered. Replacement will be covered only when the hearing aid cannot be repaired satisfactorily.

- oxygen, plasma and blood transfusions.
- 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.
- colostomy supplies.
- 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 the costs after you pay the deductible, for the following paramedical specialists, up to the maximum amounts indicated below. The reimbursement level is indicated under each option in the *Benefit Details* section. 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.

- acupuncturists, up to a maximum of \$100 per person in a benefit year.
- massage therapists (no benefit year maximum).
- physiotherapists (no benefit year maximum).
- chiropractors and naturopaths combined, \$300 each benefit year for each person up to a maximum of \$750 per family per benefit year.
- podiatrists (no benefit year maximum).

We will also cover 100% of the costs without a deductible, for licensed psychologists or social workers, or clinical counsellors who are active members of a provincial association which is approved by Sun Life up to a combined maximum of \$2,500 per person in a benefit year.

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.

The reimbursement level and the combined maximum amount payable are indicated under each option in the *Benefit Details* section. 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 Coverage ends is indicated in the *Benefit Details* section.

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 programs

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

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

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

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 date the Extended Health Care coverage terminates under this contract, whichever is earlier.

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

Teladoc Medical Experts

The services offered by Teladoc Medical Experts are not insured or administered by Sun Life.

If you, as an employee, are covered for Extended Health Care, you, your spouse, your children, your parents and your parents-in-law have access to Teladoc Medical Experts.

Teladoc Medical Experts services are available to your spouse and children even if they are not covered for Extended Health Care under this plan.

Teladoc Medical Experts offers a variety of services that can help if a person suspects or has been diagnosed with a serious medical condition. To use this service, please call Teladoc Medical Experts at 1-877-419-2378.

Liability and responsibility of Sun Life

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

Sun Life cannot guarantee the availability of Teladoc Medical Experts services.

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 Global 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.

Optional Group Travel Benefit

General description of the coverage	<p>In this section, <i>you</i> means the employee and all dependants covered for the emergency Optional Group Travel Benefit.</p> <p>To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.</p> <p>In the event of an emergency occurring while you are travelling outside your province of residence, benefits will be payable under this provision before any benefits are payable under the Extended Health Care and Emergency Travel Assistance benefits of the group plan provided to you by Sun Life.</p> <p>A \$1,000,000 maximum is available for each person insured under this benefit</p> <p>The benefit year is from January 1 to December 31.</p> <p>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.</p>
Medical care	<p>We will cover 100% of the cost of covered emergency services that are medically necessary for the treatment of an illness and are incurred while you are outside the province where you live, such as:</p> <ul style="list-style-type: none">■ a semi-private hospital room, up to a maximum of 90 days.■ other hospital services provided outside of Canada, including laboratory tests and x-rays.■ out-patient services in a hospital.■ prescription drugs required to alleviate an acute medical condition.

- the services of a doctor.
- 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. Services of an attendant are also covered.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services. Services of an attendant are also covered.

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.

For full details of this coverage, please refer to your employer. If there are any discrepancies between the information contained in this employee benefits booklet and the information in the group contract, the group contract will take priority.

Your responsibility for advances

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

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

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

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.

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 that do not qualify as medical expenses under the Income Tax Act (Canada).
- 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 programs

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

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

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

When coverage ends Optional Group Travel Benefit coverage will end on the date you retire.

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.

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

- 365 days after the end of the benefit year during which you incur the expenses, or
- 90 days after the end of your Optional Group Travel Benefit coverage, whichever is earlier.

Who to Contact

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.

If you are faced with a medical emergency when travelling outside of the province where you live, Allianz Global Assistance USA, Inc. (*Allianz Global Assistance*) can help by calling:

In the USA and Canada: 1-800-511-4610

In Mexico: 001-800-368-7878

Elsewhere call: * 202-296-7493 (call collect if available)

Toll-Free dialing is not available in Cuba. Use international operator

*Add the long distance code to contact the U.S.A.

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.

Benefit year	The benefit year is indicated in the <i>Benefit Details</i> section.
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: <ul style="list-style-type: none">■ inlay■ onlay■ crown■ veneer■ implant
Lifetime maximum	The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is indicated under each option in the <i>Benefit Details</i> section.
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. The reimbursement level is indicated under each option in the <i>Benefit</i>

Details section.

- Oral examinations*** Complete examination up to a lifetime maximum of 2 per person.
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.

The reimbursement level is indicated under each option in the *Benefit Details* section.

Fillings 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 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.

The reimbursement level is indicated under each option in the *Benefit Details* section.

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 reimbursement level and the maximum amount we will pay per person per implant are indicated under each option in the Benefit Details section.

Orthodontic procedures (Plan C)

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

The reimbursement level and maximum are indicated under each option in the *Benefit Details* section.

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 Coverage ends is indicated in the *Benefit Details* section.

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.

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

Health Spending Account

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.

Your Health Spending Account coverage pays for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received or the supplies are purchased or rented. Eligible expenses incurred by a dependant are also covered. Coverage applies only to expenses incurred after the employee becomes covered under the Health Spending Account and before the date the Health Spending Account ends.

A dependant is any person for whom you may claim a medical expense tax credit on your federal tax return in the taxation year. For example, this could include members of your extended family, such as your parents, grandparents or grandchildren.

Benefit year

The benefit year is indicated in the *Benefit Details* section.

How your Health Spending Account works

Your Health Spending Account works like an expense account. Your employer will allocate plan credits to your account in the manner described under *Plan credits*.

Each time you submit a Health Spending Account claim, either for yourself or for a dependant, you will be reimbursed for eligible expenses, up to the balance of your account. Expenses incurred in one benefit year cannot be covered by credits received in the following benefit year. If a claim exceeds your Health Spending Account balance, it will not be necessary to submit another claim for the unpaid portion of the claim. Any unpaid amount will be reprocessed automatically if additional credits are allocated into your Health Spending Account before the end of the benefit year during which the eligible expenses are incurred.

Credits can only be used to provide reimbursement for eligible expenses. Under the Income Tax Act, the definition of eligible expenses is quite wide. These expenses are shown below. Credits cannot be cashed out and will be lost unless used. You can avoid the loss of credits by using them before the end of the benefit year following the benefit year in which they have been allocated to your account, and before any earlier termination of this benefit or your coverage.

There are a number of reasons why the Health Spending Account is tax-effective for you. Eligible expenses are specifically limited to expenses not covered under another plan or under another benefit of this plan. If you paid for these expenses on your own, you would have to use expensive "after-tax" dollars. On the other hand, your Health Spending Account is sheltered from federal and provincial (except Québec) income tax. In most circumstances, this means that when you use plan credits to pay for expenses, you are using less expensive "pre-tax" dollars. The result is extra savings for you.

Continuation of coverage for dependants

The Health Spending Account is set up under the employee's name, and there cannot be any continuation of coverage for dependants after the employee's death. Only expenses incurred before the employee's death can be covered under the employee's Health Spending Account.

Plan credits

Your plan credits are indicated in the *Benefit Details* section.

Coverage includes the following items provided they qualify as tax deductible medical expenses under the Income Tax Act (Canada) **and** are not payable under any other private or government plan. If the list of items qualifying as tax deductible medical expenses under the Income Tax Act (Canada) is changed, this plan is automatically updated to reflect the changes.

Drugs ■ drugs, medications or other preparations or substances prescribed by a licensed medical practitioner or dentist.

Eyeglasses ■ eyeglasses or other devices for the treatment or correction of a patient's vision defect, as prescribed by a medical practitioner or an optometrist.

<i>Deductibles and coinsurances</i>	<ul style="list-style-type: none"> ■ deductible and coinsurance amounts under medical or dental plans.
<i>Licensed practitioners (fee for services)</i>	<ul style="list-style-type: none"> ■ acupuncturists (must be a licensed medical practitioner), chiropodists, podiatrists, chiropractors, Christian Science practitioners, naturopaths, nurses, optometrists, osteopaths, physiotherapists, practical nurses, psychoanalysts, psychologists, speech therapists (where therapy involves pathology or audiology), therapists.
<i>Dental care</i>	<ul style="list-style-type: none"> ■ preventative, diagnostic, restorative, orthodontic and therapeutic care.
<i>Attendant care</i>	<ul style="list-style-type: none"> ■ remuneration for a full-time attendant, or for the cost of full-time care in a nursing home, of a patient who has a severe and prolonged mental or physical impairment; the condition must be certified by a medical doctor or an optometrist, where applicable; an impairment is considered severe and prolonged if it markedly restricts daily activities and can reasonably be expected to last for a continuous period of at least 12 months. ■ remuneration for a full-time attendant if the patient lives in a self-contained domestic establishment (for example, his home); a doctor must certify that the patient is likely to be dependent on others for his personal needs by reason of physical or mental infirmity that is of indefinite duration.
<i>Facilities</i>	<ul style="list-style-type: none"> ■ amounts paid to a nursing home for the full-time care of a patient who, due to a lack of normal mental capacity, will be dependent upon others at that time and for the foreseeable future. ■ payments to a special school, institution or other place for care, training, or use of equipment, facilities or personnel, with regard to a mentally or physically handicapped individual; an "appropriately qualified person" must certify the individual and his or her special requirements.
<i>Hospitals</i>	<ul style="list-style-type: none"> ■ payments to a public or licensed private hospital.
<i>Devices and supplies</i>	<ul style="list-style-type: none"> ■ artificial eyes.

- artificial limbs.
- crutches.
- cloth diapers, disposable briefs, catheters, catheter trays, tubing or other products required by the patient by reason of incontinence caused by illness, injury or affliction.
- device or equipment, including a replacement part, designed exclusively for use by an individual who is suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, including the cost of an air conditioner (covered at 50% up to a maximum of \$1,000), air or water filter, electric or sealed combustion furnace purchased to replace another furnace (which was not an electric or a sealed combustion furnace), but excluding a humidifier, dehumidifier, heat pump or heat or air exchanger.
- device or equipment designed to pace or monitor the heart of an individual who suffers from heart disease.
- device designed exclusively to enable an individual with a mobility impairment to operate a vehicle.
- device or equipment, including a synthetic speech system, Braille printer and large print-on-screen device, designed exclusively to be used by a blind individual in the operation of a computer.
- device to decode special television signals to permit the vocal portion of the signal to be visually displayed.
- device designed to be attached to infants diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe.
- electronic speech synthesizer that enables a mute individual to communicate by use of a portable keyboard.
- electronic or computerized environmental control system designed exclusively for the use of an individual with a severe

and prolonged mobility restriction.

- external breast prosthesis that is required because of a mastectomy.
- extremity pump or elastic support hose designed exclusively to relieve swelling caused by chronic lymphedema.
- hearing aids.
- hospital bed, including attachments to it that may have been included in a prescription.
- ileostomy or colostomy pads.
- inductive coupling osteogenesis stimulator for treating non-union of fractures or aiding in bone fusion.
- infusion pump, including disposable peripherals, used in the treatment of diabetes or a device designed to enable a diabetic to measure his or her blood sugar level.
- insulin.
- iron lung.
- kidney machines.
- laryngeal speaking aids.
- limb braces.
- mechanical device or equipment designed to be used to assist an individual to enter or leave a bathtub or shower, or to get on or off a toilet.
- needle or syringe.
- optical scanner or similar device designed to be used by blind individuals to enable them to read print.
- orthopaedic shoe or boot, or an insert for a shoe or boot, made to

order for an individual in accordance with a prescription to overcome a physical disability of the individual.

- oxygen tent or equipment.
- power-operated lifts designed exclusively for use by disabled individuals to allow them access to different levels of a building or assist them to gain access to a vehicle, or to place wheelchairs in or on a vehicle.
- rocking bed for poliomyelitis victims.
- spinal braces.
- teletypewriter or similar device, including a telephone ringing indicator, that enables a deaf or mute individual to receive telephone calls.
- truss for a hernia.
- walkers.
- wheelchairs.
- wig made to order for an individual who has suffered abnormal hair loss owing to disease, medical treatment or accident.

Other

- costs of acquisition, care and maintenance (including food and veterinary care) of an animal, specially trained to assist a patient who is blind or profoundly deaf or has a severe and prolonged impairment that markedly restricts the use of arms or legs (the animal must be provided by a person or an organization, one of whose main purposes is such training of animals). In addition, travelling, board, and lodging expenses, while in full-time attendance at a training institution, are allowable.
- costs of medical services and supplies outside of the province of residence.
- diagnostic, laboratory and radiological procedures or services used for maintaining health, preventing disease or assisting in

diagnosis.

- modifications to a home for a person who lacks normal physical development or who is confined to a wheelchair, to enable the person to be functional or mobile.
- reasonable expenses to locate a donor for a bone marrow or organ transplant and, reasonable travelling, board and lodging expenses of the donor and the patient in respect of the transplant.
- transportation by ambulance to or from public or licensed private hospital for the patient.
- transportation expenses paid to an individual who is in the business of providing transportation services to transport the patient and one additional person (if necessary as certified by a medical practitioner) provided:
 - equivalent medical services are not available locally.
 - the route is reasonably direct.
 - the medical treatment sought is reasonable and the distance travelled is at least 40 kilometres.
- reasonable expenses for meals and accommodation for the patient and, if required, the accompanying individual, provided the conditions for transportation expenses are satisfied and the distance travelled is at least 80 kilometres.
- reasonable expenses relating to rehabilitative therapy, including training in lip reading and sign language, incurred to adjust for the patient's hearing or speech loss.

Other coverage

If you or your eligible dependants have coverage under another plan, you should submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit any unpaid portion of the claim for payment from your Health Spending Account.

When coverage ends

Coverage ends is indicated in the *Benefit Details* section.

**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 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses,
or
- the end of your Health Spending Account coverage.

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

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 indicated in the *Benefit Details* section.

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.

<i>Balance carry-forward</i>	<p>This Healthy Lifestyle Account is set up with a <i>balance carry-forward</i> 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.</p> <p>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.</p> <p>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 <i>When and how to make a claim</i>.</p>
Continuation of coverage for dependants	<p>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.</p>
Credits	<p>Your plan credit is indicated in the <i>Benefit Details</i> section.</p>
<i>Prorating</i>	<p>Prorating is indicated in the <i>Benefit Details</i> section.</p>
Eligible expenses	<p>You can use your Healthy Lifestyle Account to help you pay for the following eligible expenses:</p>
<i>Fitness-related services</i>	<ul style="list-style-type: none">■ 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, inversion tables, 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).

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- 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, chiropracist, naturopath, chiropractor, osteopath, career coaches, audiologist, dietician, occupational therapist, clinical counsellors who are active members of a provincial association which is approved by Sun Life, optometrist and ophthalmologist.
 - 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 Coverage ends is indicated in the *Benefit Details* section.

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

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

You have a choice

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

