

your **group**
benefits

Teck

Teck Resources Limited (Teck Coal)

**Coal Mountain Union Hourly (USW Local 7284) Employees
British Columbia**

**Contract Number 100258 and 150038
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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.

Your group benefits may be modified after the effective date of this booklet. 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
- Dental Care

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. 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 a permanent employee.
- you are actively working for your employer at least 24 hours a week.

- you have completed the waiting period.

For Extended Health Care benefits, 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 Dental Care benefits, Short-Term Disability and Long-Term Disability coverage, the waiting period ends on the last day of the month in which you have completed 540 hours of work.

For all other benefits, there is no waiting period.

We consider you to be actively working if you are performing all the usual and customary duties of your job with your employer for the scheduled number of hours for that day. This includes scheduled non-working days and any period of continuous paid vacation of up to 3 months if you were actively working on the last scheduled working day. We do not consider you to be actively at work if you are receiving disability benefits or are participating in a partial disability or rehabilitation program.

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.

Spouse does not include:

- a person divorced from you, or
- a person separated from you for 1 year or more, where such separation is pursuant to a court order or a legal separation

agreement, or the parties are living separate and apart without benefit of a court order or separation agreement.

Your children and your spouse's children (other than foster children) 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 an educational institution recognized under the Income Tax Act (Canada) 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

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 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.

For your Optional Life coverage and for your Spouse and Child Optional Life coverage, you must request coverage within 30 days of becoming eligible for coverage. If you do not request coverage within this time limit, you will have to provide proof of good health at your own expense.

When coverage begins

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

If you are not actively working on the date coverage would normally begin, your coverage will not begin until you return to active work.

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 and is actively pursuing normal activities.

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

For Spouse and Child Optional Life, if you are not actively working on the date Optional Life coverage would normally begin, then that coverage will not begin until you return to active work with your employer.

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, or your employer may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

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

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

- if a dependant, other than a newborn child, is hospitalized on the date when the change occurs, the change in the dependant's coverage cannot take effect before the dependant is discharged and is actively pursuing normal activities.

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 name.
- change of beneficiary.

Accessing your records

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

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

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

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

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

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-800-361-6212.

When coverage ends

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

- the date your employment ends or you retire.
- the date you are no longer actively working, except where stated

otherwise in the contract between Teck and Sun Life.

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

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 date the dependant child under age 21 starts working full time.
- the date the spouse is divorced from you.
- the date the spouse is separated from you for 1 year or more, where such separation is pursuant to a court order or a legal separation agreement, or the parties are living separate and apart without benefit of a court order or separation agreement.
- the end of the period for which premiums have been paid for dependant coverage.

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, without premiums, until the earlier of the following dates:

- the last day of the month in which you die.
- the date the person would no longer be considered your dependant under this plan if you were still alive.
- the date the benefit provision under which the dependant is covered terminates.

The continuation of coverage does not apply to Spouse and Child Optional Life.

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.

If such legislation or guidelines require that Sun Life resume paying certain benefits because of a recurrence of an employee's total disability, Sun Life will resume payment at the same amount and for the remainder of the maximum benefit period.

Making claims

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

There are time limits for making claims. These limits are discussed in the appropriate sections of this 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

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different limitation period, no legal action or proceeding may be brought against

Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for disability benefits that have been paid by Sun Life for some period of time, more than one year after the last date for which disability benefits have been paid, or
- regarding all other claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim, or
- regarding claims for *Coverage during total disability* which are initially approved, more than one year after the date you cease to be covered or your premiums cease to be waived.

Legal actions for self-insured benefits

No legal action may be brought by you more than one year after the date we must receive your claim forms.

Proof of disability

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

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.

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

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

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

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

Appropriate treatment Appropriate treatment is defined as any treatment that is performed and prescribed by a doctor or, when Sun Life believes it is necessary, by a medical specialist. It must be the usual and reasonable treatment for the condition and must be provided as frequently as is usually required by the condition. It must not be limited solely to examinations or testing.

Basic earnings Basic earnings are the regular rate of pay you receive from your employer including any regular bonuses, regular overtime or regular commissions but excluding incentive pay.

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

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

surgery needed to donate a body part to another person which causes total disability is an illness.

Retirement date If you are totally disabled, your retirement date is your 65th birthday, unless you have actually retired before then.

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.

For prescription drugs, there is a deductible of \$25 each benefit year for each person up to a maximum of \$25 per family. After this deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

For other expenses, there is no deductible.

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

Under Extended Health Care, the maximum amount we will pay for any person is \$40,000. This maximum includes expenses incurred for emergency services outside Canada.

Prescription drugs

After you pay the deductible, we will cover 100% 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.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies, excluding cotton swabs, rubbing alcohol and alcohol swabs.
- products to help a person quit smoking that legally require a prescription, up to a lifetime maximum of \$500 for each person.
- acetylsalicylic acid (ASA).
- varicose vein injections.

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:

- infant formulas (milk and milk substitutes), minerals, proteins,

vitamins and collagen treatments.

- the cost of giving injections, serums and vaccines.
- anti-obesity drugs, appetite suppressants, proteins and food or dietary supplements.
- vaccines.
- insulin jet injector device.
- drugs for the treatment of infertility.
- hair growth stimulants.
- drugs for the treatment of sexual dysfunction.
- contraceptives including oral contraceptives.
- 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.

Dispensing fee Eligible expenses for the dispensing fee are limited to \$10 for each prescription or refill.

Each time you fill a prescription, you incur a dispensing fee. For certain groups of maintenance drugs, there is a limit on the number of times that Sun Life will consider the dispensing fee as an eligible expense for that group. This is called a Dispensing Fee Frequency Limit (DFFL). The DFFL is 4 times in a benefit year. Each group of maintenance drugs has its own DFFL as does each person under this plan. If you fill your prescription more often than the drug's DFFL, dispensing fees incurred on claims that exceed the DFFL will not be eligible for reimbursement unless Sun Life approves an exception form, completed

by you and your doctor, to establish the medical necessity of more frequent dispensing.

***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.

***Other health
professionals allowed
to prescribe drugs***

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

**Hospital expenses in
your province**

We will cover 80% of the costs for hospital care in the province where you live.

We will cover out-patient services in a hospital, except for any services explicitly excluded under this benefit, and the difference between the cost of a ward and a private hospital room. The maximum amount payable is \$50 per day per person.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.

The maximum amount payable is \$20 per day up to a maximum of 180 days for treatment of an illness due to the same or related causes.

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

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.

**Expenses out of
your province**

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

For both emergency services and referred services, we will cover the cost of:

- a private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- 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.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.

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

Emergency services

We will pay 80% of the cost of covered emergency services.

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

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

leaving the province where the person lives.

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

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

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

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ 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, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Europ 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, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Europ 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.

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 Europ Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Europ 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.

***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 Europ 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.

Referred services *Referred services* must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 100% of the costs of referred services. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Medical services and equipment

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

- 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 720 hours per person per benefit year.
- transportation in a licensed ambulance in the province where you live, 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 in the province where you live, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.

- the following diagnostic services rendered outside of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:
 - laboratory tests.
 - ultrasounds.
 - MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging 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 treatment is received. The guide must be the current guide at the time that treatment is received.
- wigs following chemotherapy, 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. 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. Scooters are not covered.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of \$150 per person in a benefit year.
- surgical brassieres required as a result of surgery, up to a maximum of 4 brassieres per person in a benefit year.
- artificial limbs and eyes.

- stump socks, up to a maximum of \$200 per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 4 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes and prefabricated orthopaedic shoes, when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of \$200 in a benefit year for a person under age 21 or \$400 per benefit year for any other person.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, podiatrist or chiropodist, up to a maximum of 1 pair per person in a benefit year.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of \$400 per person over a period of 5 benefit years for dependant children under age 16 only. Repairs are included in this maximum.
- colostomy supplies.
- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.

Paramedical services

We will cover 80% of the costs, up to the maximums listed below for the following paramedical specialists:

- licensed psychologists, when ordered by a doctor, up to a maximum of \$100 per person in a benefit year.
- licensed massage therapists and physiotherapists, up to a combined maximum of \$250 per person in a benefit year.
- licensed speech therapists, when ordered by a doctor, up to a maximum of \$100 per person in a benefit year.
- licensed acupuncturists, up to a maximum of \$100 per person in a

benefit year.

- licensed chiropractors, including a maximum of one x-ray examination and licensed naturopaths, up to a combined maximum of \$200 per person in a benefit year.
- licensed podiatrists or chiropodists, including a maximum of one x-ray examination, up to a maximum of \$100 per person in a benefit year.

We will not pay for the cost of services rendered by a podiatrist in Ontario or in Alberta unless they are performed after the provincial medicare plan has paid its annual maximum benefit.

**Contact lenses,
eyeglasses or laser
eye correction
surgery**

We will cover the cost of contact lenses, eyeglasses or laser eye correction surgery. 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.

We will cover 100% of these costs up to a maximum of \$250 per person over 2 benefit years.

We will also cover services of an ophthalmologist or licensed optometrist, up to a maximum of \$50 per person over 2 benefit years.

We will not pay for sunglasses, 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 the employee retires or reaches age 71, whichever is earlier.

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

**Payments after
coverage ends**

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

- during the uninterrupted period of total disability,

- within 90 days of the end of coverage, and
- while this provision is in force.

For the purpose of this provision, an employee is totally disabled if prevented by illness from performing any occupation the employee is or may become reasonably qualified for by education, training or experience, and a dependant is totally disabled if prevented by illness from performing the dependant's normal activities.

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

What is not covered We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, 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. This limitation does not apply to *Paramedical services* or to the *dispensing fee* portion of the cost of *Prescription drugs*.
- 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.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.
- intentionally self-inflicted injuries, while sane or insane.
- operating a motor vehicle with either a blood alcohol content over the permissible level stipulated in the Criminal Code or while under the influence of any other intoxicant.

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.

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 end of your Extended Health Care coverage, whichever is earlier.

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, then the fee guide approved by the provincial Dental Association for that specialist will be used.

When a fee guide is not published for a given year, the term *fee guide* may also mean an adjusted fee guide established by Sun Life.

When deciding what we will pay for a procedure, other than a crown or a crown related procedure, bridges or dentures, we will first find out if other or alternate procedures could have been done. These alternate procedures must be part of usual and accepted dental work and must obtain as adequate a result as the procedure that the dentist performed. We will not pay more than the reasonable cost of the least expensive alternate procedure.

For an implant related crown or prosthesis, we will pay the benefit that

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

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

An expense must be claimed 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. 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.

Benefit year maximum

We will not pay more than:

- \$3,500 per covered person for each benefit year for Preventive and Basic dental procedures combined.
- \$3,500 per covered person for each benefit year for Major dental procedures.

Orthodontic expenses are not included in the benefit year maximum. A separate lifetime maximum applies.

Lifetime maximum

The maximum amount we will pay for all Orthodontic procedures in a person's lifetime is \$2,000.

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

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

Complete examination.

2 recall examinations per benefit year.

Emergency or specific examinations.

Orthodontic examinations

Orthodontic examinations, including orthodontic diagnostic services, used to treat misaligned or crooked teeth.

X-rays

1 complete series of x-rays every 36 months.

1 panorex every 60 months.

Bitewing x-rays.

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

Other services

Required consultations between two dentists, limited to 2 units of 15 minutes per consultation per benefit year.

Required consultations between the dentist and the patient limited to 2 units of 15 minutes per consultation per benefit year.

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

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 primary teeth.

Pit and fissure sealants.

Oral hygiene instruction.

Study models, 1 per benefit year.

Emergency dispensing of one or two doses of a therapeutic drug and written prescription.

Basic dental procedures

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, 1 per tooth every 24 months.

Stainless steel crown 1 per tooth every 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. You are covered for 2 treatments per tooth per lifetime, separated by at least 12 months.

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. Periodontal irrigation done in conjunction with scaling/root planing will also be considered an eligible expense.

	You are covered for up to 12 units of 15 minutes of tartar removal in a benefit year.
<i>Occlusal equilibration</i>	You are covered for up to 4 units in a benefit year.
<i>Removal and recementation</i>	Veneers, inlays, onlays or crowns.
<i>Repair</i>	Repair of veneers, inlays, onlays, crowns, bridges or dentures.
<i>Rebase or reline</i>	Rebase or reline of an existing partial or complete denture.
<i>TMJ expenses</i>	Charges related to the temporomandibular joint (TMJ) treatment.
<i>Onlays</i>	1 per tooth every 60 months.
<i>Oral surgery</i>	Surgery and related anaesthesia, other than the removal of impacted teeth (<i>Preventive dental procedures</i>). It includes surgery required for the treatment of maxillofacial deformities.
<i>Alveoloplasty.</i>	This procedure includes remodelling, excision, removal and reduction of bone.
<i>Maxillofacial prosthesis</i>	Obturators or speech aid prosthesis.
<i>Miscellaneous</i>	<ul style="list-style-type: none"> ■ retentive pins with inlays, onlays or crowns. ■ onlay post and core.
Major dental procedures	<p>Your dental benefits include the following procedures used to treat major dental problems.</p> <p>We will pay 80% of the eligible expenses for these procedures.</p>
<i>Major restorations</i>	<ul style="list-style-type: none"> ■ inlays – 1 per tooth every 60 months. ■ crowns – 1 per tooth every 5 years. ■ veneers – 1 per tooth every 60 months.
<i>Prosthodontics</i>	Construction and insertion of bridges or standard dentures. Charges for

a replacement bridge or replacement standard denture are not considered an eligible expense during the 5 year period following the construction or insertion of a previous bridge or standard denture unless:

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

Orthodontic procedures

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

We will pay 50% of the eligible expenses for these procedures.

Coverage includes 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 the employee retires or reaches age 71, whichever is earlier. If your employment ends, you will continue to be covered for expenses related to the installation of a crown, onlay or bridge if an impression was taken while you were covered under this plan and if the expense is incurred within 31 days after the end of your Dental Care coverage.

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

Payments after coverage ends

If the Dental Care benefit terminates, you will still be covered for procedures to repair natural teeth damaged by an accidental blow if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for 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.
- procedures or supplies used in full mouth reconstructions (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- transplants, and repositioning of the jaw.
- 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.
- participation in a criminal offence.
- intentionally self-inflicted injuries, while sane or insane.
- operating a motor vehicle with either a blood alcohol content over the permissible level stipulated in the Criminal Code or while under the influence of any other intoxicant.

When and how to make a claim

To make a claim, complete the claim form that is available from your employer. 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 end of your Dental Care coverage, 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.

Short-Term Disability (Weekly Indemnity)

General description of the coverage

Short-Term Disability coverage provides a benefit if you become totally disabled. You qualify for this benefit if you present proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since its onset.

For the purposes of your Short-Term Disability coverage, you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation.

Your benefits will be based on your coverage on the date you became totally disabled. Benefits are paid at the end of each week for which you are entitled to payments.

When disability payments begin

If you become totally disabled because of an **accident** and your total disability begins within 30 days of the accident, you will be eligible for Short-Term Disability payments on the date you become totally disabled or the first day you consult a doctor, whichever is later.

If you become totally disabled because of an **illness**, you will be eligible for Short-Term Disability payments as follows:

- if you work a 8 or 10 hour shift – after 3 days of uninterrupted total disability or the first day you consult a doctor, whichever is later.
- if you work a 12 hour shift – after 2 days of uninterrupted total disability or the first day you consult a doctor, whichever is later.

If you become totally disabled because of a drug or alcohol addiction, in accordance with the employer's drug and alcohol policy, the

elimination period cannot begin until the date an assessment is completed by Homewood Human Addiction Counsellor or by an addiction doctor selected by the employer.

The period, which must be completed before disability benefits become payable, is the **elimination period**.

In any case, you will be eligible for Short-Term Disability payments on the date you are hospitalized or undergo surgery, including laser surgery, or chemotherapy.

Short-Term Disability benefits are paid only for the scheduled working days that you are totally disabled. If you are totally disabled for part of any week, the weekly benefit will be based on the number of days you were scheduled to work.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for at least the elimination period described above in the case of illness and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer. In the case of an accident, you must be totally disabled on the date you are recalled or scheduled to return to full-time work.

Interrupted periods of disability

If you had a total disability for which we paid Short-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous total disability if it occurs within 2 weeks of the end of your previous disability. You must be covered when the total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability and will be paid for no longer than the rest of the maximum benefit period.

What we will pay

Here is how we calculate your Short-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take 60% of your weekly basic earnings up to a maximum of \$600 or the maximum sickness benefit under the Employment Insurance Act, whichever is greater.

If your Short-Term Disability benefit is less than the benefit that would be payable under the Employment Insurance Act, your basic earnings will be increased by the amount of bonus, commission, overtime or incentive pay earned on a regular basis, required to calculate the amount of benefit payable under the Employment Insurance Act.

Step 2: We subtract any income provided to you:

- under a motor vehicle insurance plan which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining the amount of benefits payable under the motor vehicle insurance plan, and as long as the law does not prohibit such a deduction.
- from any employer, including vacation pay.
- as wages, income, severance or any other form of termination pay provided to you by the employer relating to the termination of your employment or your entitlement to either or both statutory or common law notice, regardless of whether such payment is part of a lump sum payment or settlement or salary continuation.
- under the Québec Parental Insurance Plan.

After the first 17 weeks of total disability, when the maximum benefit period is more than 17 weeks, we also subtract any income provided to you:

- for the same or a subsequent disability under the Canada Pension Plan (CPP) or Québec Pension Plan (QPP), excluding dependant benefits, employment insurance benefits and automatic cost-of-living increases that occur after benefits begin.

The result from Step 2 is the amount you would receive as a Short-Term Disability payment.

If you are eligible for any of the income amounts above and do not

apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a weekly basis using generally accepted accounting principles.

We will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

We have the right to adjust your benefit payments when necessary.

**Maternity / parental
leave of absence**

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Short-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for the elimination period in the case of illness described under *When disability payments begin* or the date you are hospitalized if earlier, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit

(SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

It may include the involvement of our rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive Short-Term Disability payments plus income from other sources. However, if during any week your total income is more than 100% of your basic earnings when your disability began (less provincial and federal income taxes if your benefit is non-taxable), your Short-Term Disability payment will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled.

If you recover damages from another person

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

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

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

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

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- When payments end** Your Short-Term Disability payments end on the earlier of the following dates:
- the date you are no longer totally disabled.
 - the end of a maximum benefit period of 52 weeks of payment.
 - the date you retire on pension.
 - the date you die.
- When coverage ends** Your Short-Term Disability coverage will end on the last day of the month in which you retire or reach age 71, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.
- Payments after coverage ends** If the Short-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.
- What is not covered** We will not pay benefits for any period:
- you are not receiving appropriate treatment.
 - that you do any work for wage or profit except as approved by Sun Life.
 - you are not participating in an approved rehabilitation program, if required by Sun Life.
 - you are on a leave of absence, strike or lay-off, except where specifically agreed to by Sun Life. However, if you become totally disabled before a notice of separation is given, payments continue while you are totally disabled, but not beyond the end of the maximum benefit period.
 - you are on a maternity and/or parental leave except as stated under *Maternity / parental leave of absence*.
 - you are absent from Canada longer than 4 weeks due to any

reason, unless Sun Life agrees in writing in advance to pay benefits during the period.

- you are serving a prison sentence or are confined in a similar institution.

We will not consider you totally disabled if your disability results from drug or alcohol abuse. However, this limitation will not apply while you are participating in a Sun Life approved treatment program, while you are on a waiting list to begin treatment that has been approved by Sun Life or if you have an organic disease which would cause total disability even if drug and alcohol abuse ended.

We will not pay if benefits are payable to you under any Workers' Compensation Act or similar legislation.

We will not pay for total disability resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- intentionally self-inflicted injuries or attempted suicide, while sane or insane.
- participation in a criminal offence.
- operating a motor vehicle with either a blood alcohol content over the permissible level stipulated in the Criminal Code or while under the influence of any other intoxicant.

When and how to make a claim

To make a claim, claim forms that are available from your employer must be completed. You, the attending doctor and your employer will all have to complete claim forms.

In order for you to receive benefits, we must receive these forms no later than 180 days after your total disability begins.

We will assess the claim and send you and your employer a letter outlining our decision.

From time to time, Sun Life can require that you provide us with proof

of your total disability. If you do not provide this information within 90 days of the request, you will not be entitled to benefits.

Long-Term Disability

General description of the coverage

Long-Term Disability coverage provides a benefit to you if you are totally disabled. You qualify for this benefit if you provide proof of claim acceptable to Sun Life that:

- you became totally disabled while covered, and
- you have been following appropriate treatment for the disability since its onset.

For your Long-Term Disability coverage,

- during the elimination period and the following 18 months (this period is known as the **own occupation period**), you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

Benefits are paid at the end of each month and are based on your coverage on the date you became totally disabled.

If you are totally disabled for part of any month, we will pay 1/30 of the monthly benefit for each day you are totally disabled.

When disability payments begin

Your Long-Term Disability payments begin after you have been totally disabled for an uninterrupted period of 52 weeks or after the last day benefits are payable under any short-term disability, loss of income or other salary continuation plan, whichever is later.

This period, which must be completed before disability benefits become payable, is the **elimination period**.

If you become totally disabled during a lay-off or approved leave and your coverage continues during this time, you will be eligible for benefit payments following your recall or scheduled return to full-time work with your employer. You must have been totally disabled for an uninterrupted period of 52 weeks and still be totally disabled on the date you are recalled or scheduled to return to full-time work with your employer.

What we will pay

Here is how we calculate your Long-Term Disability payments. All references to income in this disability provision are to the gross amounts before any deductions.

Step 1: We take \$1,500.

Step 2: We subtract any income provided to you:

- for the same or a subsequent disability under the Canada Pension Plan (CPP) or Québec Pension Plan (QPP), excluding dependant benefits, employment insurance benefits and automatic cost-of-living increases that occur after benefits begin.
- for the same or a subsequent disability under any Workers' Compensation Act or similar law, excluding automatic cost-of-living increases that occur after benefits begin.
- under the Québec Parental Insurance Plan.

The result from Step 2 is the amount you will normally receive.

If this amount plus the above sources of income and all the additional sources of income listed below exceeds 85% of your pre-disability basic earnings, we will reduce your Long-Term Disability payment by the excess. If your benefit is non-taxable, the maximum will be 75% of your pre-disability basic earnings after income tax.

Additional sources of income provided to you:

- under any government-sponsored plan on behalf of a dependant for the same or a subsequent disability, excluding employment insurance benefits and automatic cost-of-living increases under

any government-sponsored plan that occur after benefits begin.

- under any Workers' Compensation Act or similar law for another disability, excluding any automatic cost-of-living increases that occur after benefits begin.
- under any Criminal Injuries Compensation Act or similar law, where allowed by law.
- under a motor vehicle insurance plan which provides disability benefits to the extent that the law does not prohibit such a deduction.
- under a group plan, including any coverage resulting from your membership in an association of any kind.
- under a retirement or pension plan funded in whole or in part by the employer, as a result of your disability or a medical condition.
- from any employer, including vacation pay.
- as wages, income, severance or any other form of termination pay provided to you by the employer relating to the termination of your employment or your entitlement to either or both statutory or common law notice, regardless of whether such payment is part of a lump sum payment or settlement or salary continuation.

If you are eligible for any of the income amounts above and do not apply for them, we will still consider them part of your income. We can estimate those benefits and use those amounts when we calculate your payments.

If you receive any of the income amounts above in a lump sum, we will determine the equivalent compensation this represents on a monthly basis using generally accepted accounting principles.

We will not take into account any benefits that began before your disability began. However, increases in those benefits as a result of your disability will be taken into account.

We have the right to adjust your benefit payments when necessary.

**Maternity / parental
leave of absence**

Maternity leave agreed to with your employer will begin on the date you and your employer have agreed will be the start of your leave or the date the child is born, whichever is earlier. The leave will end on the date you and your employer have agreed that you will return to active, full-time work or the actual date you return to active, full-time work, whichever is earlier.

Parental leave is the period of time that you and your employer have agreed on.

Sun Life will determine any portions of a maternity or parental leave which are voluntary and any portions which are health-related. The health-related portion of the leave is the period in which a woman can establish, through appropriate medical documentation, that she is unable to work for health reasons related to childbirth or recovery from childbirth.

Long-Term Disability benefits will only be payable for health-related portions of the leave where necessary in order to comply with requirements such as employment standards, human rights and employment insurance, after you have been disabled for an uninterrupted period of 52 weeks, provided your coverage has been continued.

However, if your employer has a Supplemental Unemployment Benefit (SUB) plan as defined in the Employment Insurance regulations covering the health-related portion of the maternity or parental leave, Sun Life will not pay any benefits under this plan during any period benefits are payable to you under your employer's SUB plan.

**Partial disability
program**

You may be required to participate in a partial disability program approved by Sun Life in writing.

After you are eligible for Long-Term Disability payments, you may be considered for a partial disability program in which you return to your own occupation for a reduced number of hours per week.

During your partial disability program, you can receive a salary from your employer for the hours worked. However, your Long-Term

Disability payments will be reduced by the percentage of your normal work week that you are now working for your employer.

During your partial disability program your total income from all sources cannot exceed 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable). If this is the case, your Long-Term Disability payments will be further reduced by the excess.

Your participation in a partial disability program will be limited to the own occupation period.

Rehabilitation program

You may be required to participate in a rehabilitation program approved by Sun Life in writing.

It may include the involvement of our rehabilitation specialist, part-time work, working in another occupation or vocational training to help you become capable of full-time employment.

Sun Life is under no obligation to approve or continue a rehabilitation program for an employee. We will consider such factors as financial considerations and our opinion on the merits of rehabilitation.

During your rehabilitation program, you may receive your Long-Term Disability payments plus income from other sources. However, if during any month your total income is more than 100% of your pre-disability basic earnings, indexed for inflation (less provincial and federal income taxes if your benefit is non-taxable), your Long-Term Disability payments will be reduced by the excess.

You should consider participating in a rehabilitation program as soon as possible after becoming totally disabled. If you enter a rehabilitation program during the elimination period, it will not be considered an interruption of the elimination period.

Interrupted periods of disability during elimination period

Interrupted periods of total disability due to the same or related causes occurring before the elimination period has been completed are treated as one period of disability and are accumulated to complete the elimination period as long as this benefit is in force and all of the following conditions are met:

- there is no interruption of more than 3 weeks.
- each period of total disability is completed within 12 months after the start of the elimination period, or as approved by Sun Life in advance in cases where the elimination period is 365 days or more.

The difference between your normal number of scheduled hours and the number of hours actually worked is credited towards the elimination period.

If the Long-Term Disability benefit terminates, any balance of the elimination period must subsequently be completed by uninterrupted total disability.

Interrupted periods of disability after payments begin

If you had a total disability for which we paid Long-Term Disability benefits and total disability occurs again due to the same or related causes, we will consider it a continuation of your previous disability if it occurs within 1 month 2 weeks of the end of your previous disability. You must be covered when total disability reoccurs.

These benefits will be based on your coverage as it existed on the original date of total disability.

If you recover damages from another person

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

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

If you recover money, you must pay us 75% of your net recovery or the total disability income benefits paid or payable to you under this plan, whichever is less. Your net recovery does not include your legal costs. Seventy-five percent of your net recovery must be held in trust for us.

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

Your responsibilities During your total disability, you must make reasonable efforts to:

-
- recover from your disability, including participating in any reasonable treatment or rehabilitation program and accepting any reasonable offer of modified duties from your employer.
 - return to your own occupation during the first 18 months that benefits are payable.
 - obtain training in order to qualify for another occupation if it becomes apparent that you will not be able to return to your own occupation within the first 18 months that benefits are payable.
 - try to obtain work in another occupation after the first 18 months that benefits are payable.
 - obtain benefits that may be available from other sources.

If you do not, Sun Life may hold back or discontinue benefits.

When payments end Your Long-Term Disability payments end on the earlier of the following dates:

- the date you are no longer totally disabled.
- the last day of the month in which you reach age 65.
- the last day of the month in which you retire with a pension.
- the last day of the month in which you die.

When coverage ends Long-Term Disability coverage will end on the day you reach age 65 less the elimination period of 52 weeks or the day you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Payments after coverage ends If the Long-Term Disability benefit terminates while you are totally disabled, you are entitled to continue receiving payments, as long as your total disability is uninterrupted, as if the benefit were still in effect.

What is not covered We will not pay benefits for any period:

- you are not receiving appropriate treatment.
- that you do any work for wage or profit except as approved by Sun Life.
- you are not participating in an approved partial disability or rehabilitation program, if required by Sun Life.
- you are on a leave of absence, strike or lay-off, except where specifically agreed to by Sun Life.
- you are on a maternity and/or parental leave except as stated under *Maternity / parental leave of absence*.
- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.
- you are serving a prison sentence or are confined in a similar institution.

We do not pay benefits if your disability results directly or indirectly from a condition which existed on or before the date your coverage began. However, this limitation will not apply to you if you became totally disabled more than 12 months after your coverage began.

If your coverage ends but you are covered again under this plan, we will use the latest date your coverage began when applying the above limitation.

We will not consider you totally disabled if your disability results from drug or alcohol abuse. However, this limitation will not apply while you are participating in a Sun Life approved treatment program, while you are on a waiting list to begin treatment that has been approved by Sun Life or if you have an organic disease which would cause total disability even if drug and alcohol abuse ended.

We will not pay benefits for total disability resulting from:

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

- intentionally self-inflicted injuries or attempted suicide, while sane or insane.
- participation in a criminal offence.
- operating a motor vehicle with either a blood alcohol content over the permissible level stipulated in the Criminal Code or while under the influence of any other intoxicant.

When and how to make a claim

To make a claim, complete the Notice of Claim for Group Long-Term Disability Benefits that is available from your employer.

We must receive notice of claim on the earlier of the following dates:

- 60 days after the total disability begins.
- within 30 days of the termination of this Long-Term Disability benefit.

Part of the application process will include filling out claim forms that give us as many details about the claim as possible. You, the attending doctor and your employer will all have to complete claim forms.

In order to receive benefits, we must receive these forms no later than 180 days after the end of the elimination period.

We will assess the claim and send you or your employer a letter outlining our decision.

From time to time, Sun Life can require that you provide us with proof of your total disability. If you do not provide this information within 90 days of this request, you will not be entitled to benefits.

Life Coverage

General description of the coverage Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependants' Life coverage provides a benefit if one of your dependants dies while covered.

Basic Life coverage for you

Amount Your Life benefit is \$65,000.

Coverage ends Your coverage will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for you

Amount You can choose coverage of \$50,000.

Coverage ends Your coverage will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your spouse

Amount You can choose Optional Life coverage of \$25,000 for your spouse.

Coverage ends Optional coverage for your spouse will end when you retire. Coverage may also end on an earlier date, as specified in *General Information*.

Optional Life coverage for your children

Amount You can choose Optional Life coverage of \$10,000 for your children.

Coverage ends Optional coverage for your children will end when you retire, whichever is earlier. Coverage may also end on an earlier date, as specified in *General Information*.

Who we will pay

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

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

If a dependant dies, Sun Life will pay you the benefit for that dependant.

For your spouse's optional coverage, Sun Life will pay the full amount of the benefit to the last named beneficiary on file with Sun Life. If you have not named a beneficiary, the benefit amount will be paid to you.

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

Suicide

If you or a dependant have any optional coverage that has been in effect for less than 1 year, we will not pay benefits if death is by suicide, while sane or insane. However, we will refund all applicable Life coverage premiums that have been paid.

Coverage during total disability

If you become totally disabled before you retire or reach age 65, whichever is earlier, Life coverage may continue without the payment of premiums as long as you are totally disabled. This continued coverage is subject to the terms of the contract which were in effect on the date you became totally disabled, including reductions and terminations.

Sun Life must receive proof of your total disability within 180 days of the date the disability begins. After that, we can require ongoing proof that you are still totally disabled.

If proof of total disability is approved after an individual insurance policy becomes effective as a result of converting the group Life coverage, the group Life coverage will be reduced by the amount of the individual insurance policy, unless the individual insurance policy is exchanged for a refund of premiums.

Total disability must continue for:

- an uninterrupted period of 52 weeks if you are not entitled to Long-Term Disability payments, or
- the elimination period for Long-Term Disability if you are entitled to Long-Term Disability payments.

This coverage will continue without payment of premiums, from the date total disability begins, until the date you cease to be totally disabled or the date you fail to give Sun Life proof of your continued total disability, whichever is earlier.

If you stop being totally disabled following a total disability for which premiums are waived and, within 1 month and 2 weeks, total disability occurs again due to the same or related causes, we will consider it a continuation of your previous disability. The continued coverage will be based on your coverage as it existed on the original date of disability.

Spouse Optional Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Spouse Optional Life benefit is terminated.

Child Optional Life coverage will also continue without payment of premiums, as long as your Life coverage is continued without payment of premiums, but not after the Child Optional Life benefit is terminated.

For the purposes of your Life coverage,

- for the first 52 weeks and the following 24 months (this period is known as the **own occupation period**), you will be considered totally disabled while you are continuously unable due to an illness to do the essential duties of your own occupation, and
- afterwards, you will be considered totally disabled if you are continuously unable due to an illness to do any occupation for which you are or may become reasonably qualified by education, training or experience.

However, if you are totally disabled under the Long-Term Disability benefit, you are also considered to be totally disabled under the Life benefit.

Converting Life coverage

If your Life coverage ends or reduces for any reason other than your request, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

If your spouse's Life coverage ends for any reason other than your request, your spouse may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

Where necessary in order to comply with applicable legislation: If your child's Life coverage ends due to the termination of your Life coverage, you may apply to convert the group Life coverage for your child to an individual Life policy with Sun Life without providing proof of good health.

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

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

When and how to make a claim

The claim must be received by Sun Life within 90 days after the death occurred. Claim forms are available from your employer.

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.

Policy Number: _____

**Plan Member Certificate
Number:** _____

Teck Coal Contact: _____

Name: _____

Phone: _____