your group benefits

Teck

Trail Union Employees Local 480

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Benefit Summary

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

General Information

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

Extended Health Care

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

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

Healthy Lifestyle Account (Personal Spending Account)

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

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

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

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

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

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

Who qualifies as your dependant

Your dependant must be your spouse or your child

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

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

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

Changes affecting your coverage

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

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

Updating your records

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

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

When coverage ends

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

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

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

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

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

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

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

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:

where that practice is located.

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

against all eligible expenses for those injuries.

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

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

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

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

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

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

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

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

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

Other health professionals allowed to prescribe drugs

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

Medical services and equipment

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

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications can not perform the duties. There is a limit of $10,000 per person per benefit year up to a lifetime maximum of $25,000.
- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.
- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.
- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the employee lives. The guide must be the current guide at the time that treatment is received.
- wigs required as a result of an illness, up to a lifetime maximum of $500 per person. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our

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

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

Predetermination

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

Paramedical services

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

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

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.

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

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

Vision care

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

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

The deductible does not apply to vision care expenses.

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

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

When coverage ends

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

programs

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

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

When and how to make a claim

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

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

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

whichever is earlier.

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

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.

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.

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

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

The benefit year is from January 1 to December 31.

Deductible

There is no deductible for this coverage.

Limitation on payments

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

- inlay
- onlay
- crown
- veneer
- implant

Lifetime maximum

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

Predetermination

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

Preventive dental procedures (Plan A)

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

Basic dental procedures (Plan A)

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

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

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

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

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

Endodontics Root canal therapy and root canal fillings, and treatment of disease of the pulp tissue.

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

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

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

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

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

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

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

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

Orthodontic procedures (Plan C)

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

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

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

The following orthodontic procedures are covered:

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

When coverage ends

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

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

What is not covered

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

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

We will not pay for:

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

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.

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

Balance carry-forward

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

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

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

Continuation of coverage for dependants

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

Credits

$300 on the commencement of each benefit year.

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

Eligible expenses

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

Fitness-related services

- fitness club memberships.

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

When coverage ends

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

When and how to make a claim

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

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

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