Sun Life Financial

your group benefits

Teck

British Columbia, Territories, Manitoba and Trail retirees
Class 900

Contract Number 150039
Effective September 1, 2012

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General Information

About this booklet

The information in this retiree benefits booklet is important to you. It provides the information you need about the group benefits available through Teck Resources Limited (*Teck*)'s group plan 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 retiree benefits booklet, or you need additional information about your group benefits, please contact Teck.

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

Eligibility

Eligibility for coverage under this contract is determined by Teck at the time of retirement, consistent with the policies in place for each retiree group or location.

You must be a resident of Canada and have been covered under Teck's group plan on the day preceding your retirement. In addition, to be eligible for the Extended Health Care coverage, you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

Your dependants become eligible for coverage on the date you become eligible. No further dependants will be added under the plan after the date you retire.

Who qualifies as your dependant

Your dependant must be your spouse, your child or your spouse's 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.

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 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. Teck can give you more information about this.

Enrolment

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

When coverage begins

Coverage for you and your dependants who are eligible on the date you retire will begin on the 1st day of the month coincident with or next following the date you retire.

Updating your records

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

- change of dependants.
- change of name.

When coverage ends

Your coverage will end on the date the group plan terminates.

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

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

If you die while covered by this plan, your coverage ends. However, coverage for your eligible dependant spouse will continue until the date of your spouse's death. In no circumstances will coverage be provided after the date the benefit provision under which the dependant is covered terminates.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You 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 retiree benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

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

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

Coordination of benefits

If you or your dependants are covered for Extended Health Care 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/retiree. If the person is an employee/retiree 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.

Teck can help you determine which plan you should claim from first.

Recovering overpayments

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

Definitions

Here is a list of definitions of some terms that appear in this retiree 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.

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.

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 retiree and all dependants covered for Extended Health Care benefits.

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

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

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

The benefit year is from January 1 to December 31.

Deductible

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

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

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

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

against all eligible expenses for those injuries.

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

Reimbursement level

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

Lifetime maximum benefit

Under Extended Health Care, the maximum amount we will pay in a person's lifetime is $100,000 while you are covered under Teck's group plan, as both an active and a retired employee. This maximum also includes expenses incurred for emergency services outside Canada.

Prescription drugs

We will cover 80% of the cost after you pay the deductible, for 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.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- vitamin B12 injections for pernicious anemia.
- allergy extracts and allergy serums.
- diabetic supplies, including syringes, insulin preparations, needles and test strips, but excluding cotton swabs, rubbing alcohol and alcohol swabs.
- oral contraceptives for medical reasons.
- autolet/monolet (blood letting device).

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.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- products to help you quit smoking.
- vaccines.
- drugs for the treatment of infertility.
- contraceptives including oral contraceptives, except as otherwise provided under the list of eligible expenses above.
- varicose vein injections.
- injectable drugs and vitamins, except as otherwise provided under the list of eligible expenses above.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

BC Fair PharmaCare You are required, as a condition of coverage, to take all reasonable

drug insurance plan

steps to qualify and obtain the fullest extent of reimbursement available under BC Fair PharmaCare.

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

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

Dispensing fee

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

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 and supplies listed below when ordered by a doctor (the services of a licensed dentist do not require a doctor's order).

- registered nurse (RN) services when medically necessary. Services must be for nursing care, and not for custodial care. The registered nurse (RN) must be licensed, certified or registered in the province where you live and can not normally live with you. 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 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. Services of an attendant are also covered.
- 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. Services of an attendant are also covered.

- dental services, including braces and splints, to repair damage to natural or prosthetic 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 retiree lives. The guide must be the current guide at the time that treatment is received.

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

- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.

- transcutaneous electrical nerve stimulation (TENS) machines.

- therapeutic electrical muscle stimulators (TEMS).

- (CPAP) constant positive airway pressure machine.

- rigid abdominal, back, spinal and wrist supports.

- bed rail, grab bars, raised toilet seat, commode or transfer board for bath and toilet.

- casts, splints, trusses, braces, crutches, walkers, collars, cane or cane tips

- breast prostheses required as a result of surgery.

- surgical brassieres required as a result of surgery, up to a maximum of $150 per person in a benefit year.

- artificial limbs, eyes and larynxes. For myoelectric limbs, eligible

expenses are limited to the cost of a standard prosthesis.

- stump socks, up to a maximum of $200 per person in a benefit year.
- elastic support stockings, including pressure gradient hose, up to a maximum of 4 pairs per person in a benefit year.
- gloves for donning support stockings, up to a maximum of 12 pairs per person in a benefit year.
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a doctor, chiropractor, podiatrist or chiropodist for congenital or post traumatic foot problems, up to a maximum of 4 pairs per benefit year for a person under age 19 or 2 pairs per benefit year for any other person.
- bone growth stimulators (electromagnetic or ultrasound) when recommended by an orthopaedic surgeon.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $300 for children under age 21 over a period of 5 benefit years. Repairs are included in this maximum.
- oxygen, plasma and blood transfusions.
- breathing units, respirators, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators.
- glucometers prescribed by a diabetologist or a specialist in internal medicine.
- colostomy, ostomy and ileostomy supplies.
- insulin pumps.
- heart monitors and cardiac screeners.

Predetermination

You must 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:

- licensed psychologists, up to a maximum of $100 per person in a benefit year. Charges for tests ordered by a psychologist are not covered.
- licensed massage therapists or orthotherapist.
- licensed physiotherapists. We will not pay for the cost of services rendered in the person's home.
- licensed naturopaths and licensed chiropractors, limited to a combined maximum of $200 per benefit year for each person up to a maximum of $500 per family.
- licensed podiatrists.

Hospital expenses in your province

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

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

If chronic care is provided in a hospital or a chronic care hospital including Poplar Ridge Pavilion, the maximum amount payable is $10.50 per day. The deductible does not apply to these expenses.

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 (other than for chronic care) in a hospital.

A *chronic care hospital* is a licensed hospital that provides chronic care for patients who are chronically ill and/or have a functional disability (physical or mental), whose chronic care needs cannot be provided at home, whose potential for rehabilitation may be limited, and who require a range of therapeutic services, medical management and/or skilled nursing care not available elsewhere. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

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 while you are outside the province where you live but within Canada.

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

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

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you live (within Canada for referred services), subject to the reimbursement

level and all conditions applicable to those expenses.

Emergency services

We will pay 100% of the cost of covered emergency services after you pay the deductible.

We will only cover emergency services obtained within 365 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.

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 after you pay the deductible. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

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

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the reasonable and usual rates in the locality where the services or supplies are provided.
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- any services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments. *Experimental or investigational treatments* mean treatments that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integration with government programs

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

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

of:

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

When and how to make a claim

To make a claim, complete the claim form that is available from Teck.

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

- the end of the benefit year following the year in which you incur the expenses, or
- 90 days after the date the Extended Health Care coverage terminates under this contract, whichever is earlier.

Emergency Travel Assistance

General description of the coverage

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

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

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

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

This benefit, called **Medi-Passport**, supplements the emergency portion of your Extended Health Care coverage. It only covers emergency services that you obtain within 365 days of leaving the province where you live. If hospitalization occurs within this time period, in-patient services are covered until you are discharged.

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

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

Getting help

At the time of an emergency, you or someone with you must contact Europ Assistance. 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.**

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

Europ Assistance may arrange for:

On the spot medical assistance

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

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

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

Transportation home or to a different medical facility

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.

Repatriation

If you die while out of the province where you live, Europ Assistance will arrange for all necessary government authorizations and for the return of your remains, in a container approved for transportation, to the province where you live. We will pay a maximum of $1,000 per return.

Legal assistance

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

Lost luggage or documents

If your luggage or travel documents become lost or stolen while you are travelling outside of the province where you live, Europ Assistance will attempt to assist you by contacting the appropriate authorities and by providing directions for the replacement of the luggage or documents.

Coordination of coverage

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and 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.

Reimbursement of expenses

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

To receive reimbursement, you must provide Sun Life with proof of the

expenses within 30 days of returning to the province where you live. Teck can provide you with the appropriate claim form.

Your responsibility for advances

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

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

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

Limits on Emergency Travel Assistance coverage

Europ 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 Europ Assistance services during your trip.

Europ 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 Europ Assistance to fully provide service to the best of its ability during any such occurrence.

Liability of Sun Life or Europ Assistance

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

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.

How to Reach *Sun Life*

- Call the Customer Care Centre at 1.800.361.6212 and select Option 3. Provide your identification number and policy number indicated on your wallet ID card.
- Register for the Sun Life plan member website by calling the Customer Care Centre or by signing in to **www.mysunlife.ca**
  Click on **Register Now** and follow the prompts.
- The Sun Life plan member website provides information on your claims history and claim payments. If you wish to review this information, you must register for the website.

Mailing Address: Sun Life Assurance Company of Canada
PO Box 11641 Stn CV
MONTREAL QC H3C 5Z7

How to Reach Retiree Relations at Teck Resources Limited

- Toll-free: 1.866.533.8880 Press 1 or 2.
- Local Vancouver calls: 604.699 4097 or 604.699.4179

Emergency Assistance – Out-of-Province

Europ Assistance Call Centre – Open 24 hours a day.

- In the USA and Canada, call: 1.800.511.4610
- In Mexico, call: 011.800.368.7878
- Elsewhere, call: 202.296.7493 (call collect, if available.
  Add the long distance code to contact the USA).
- Toll-free dialing is not available in Cuba. Use International Operator.
- Fax: 202.331.1528 (Add the long distance code to contact the USA).
- E-mail: ops@europassistance-usa.com.