Contract Number: 101833, 101933 and 150533
Effective: November 1, 2023
Issued: November 23, 2023

your group benefits

British Columbia Hydro and Power Authority

MoveUp (COPE) & IBEW Retirees – Basic Option

MoveUp (COPE) & IBEW Retirees – Extra Option

BC Hydro

Sun Life Financial

Table of Contents

How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a **Sun Life Customer Care** representative for assistance with your coverage by calling toll-free at **1-800-361-6212**.

For faster service, have your mySunLife.ca numerical **Access ID** (your group contract number) and **Member ID** (the 10 digit number displayed on your drug card) ready to enter into our automated telephone system.

Plan Member Services

Download the my SunLife Mobile App!

- Free from BlackBerry App World, the Apple App Store or Google Play, anytime (Other smartphone users can access my SunLife Mobile at m.mysunlife.ca)
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

Access to mySunLife

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

Your Drug and Travel Card

Provided by your employer or online at www.mysunlife.ca.

Need to contact Sun Life's Emergency Travel Assistance provider?

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

Benefit Summary

The information contained in this summary applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator.

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care – Contract Number 150533

	Class A (Basic Option)	Class B (Extra Option)
Benefit year	January 1 to December 31	
Deductible	For prescription drugs – $5 for each prescription or refill* For other expenses: • individual – $25 per benefit year • family – $25 per benefit year	For prescription drugs – $5 for each prescription or refill* For other expenses – none
Reimbursement level	For all eligible expenses, the reimbursement percentages are described below. However, for Prescription drugs, In-province hospital, Medical services & equipment and Paramedical services combined, the reimbursement percentages described below apply to the first $1,000 of paid expenses per person per benefit year. Thereafter, these eligible expenses are paid at 100%.	As described below
Drug card plan	Included	Included
Prescription drugs	80% after the deductible	100% after the deductible
	We will cover 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 injectable vitamins • compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN • diabetic supplies (*the prescription drug deductible does not apply to these expenses) • drugs for the treatment of infertility, up to a lifetime maximum of $15,000 per person • varicose vein injections Products to help a person quit smoking that have a Drug Identification Number (DIN) or a Natural Product Number (NPN), up to a maximum of $150 per person per benefit year, provided that they are prescribed by a doctor or dentist and obtained from a pharmacist. There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.	
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.	
Drug substitution limit	We will not cover charges above the lowest priced equivalent drug unless the doctor specifies in writing that no substitution for the prescribed drug may be made	
In-province hospital	80%, after the deductible, of the difference between the cost of a ward and a private room	100% of the difference between the cost of a ward and a private room
Convalescent hospital	80% after the deductible	100%
Out-of-province emergency services	80% without the deductible for ambulance charges outside of Canada 100% without the deductible for all other eligible expenses Emergency Travel Assistance included	100% Emergency Travel Assistance included
Out-of-province referred services	100% after the deductible	100%
Travel for medical care for cancer treatment for persons who reside in British Columbia	100% after the deductible	100%
Medical services and equipment	80% after the deductible	100%
Paramedical services	80%, after the deductible, up to the maximums for the qualified paramedical practitioners listed below:	100%, up to the maximums for the qualified paramedical practitioners listed below:
	• massage therapists - up to a maximum of $10 per visit for the first 12 visits per benefit year. There is no per visit maximum for additional visits during the same benefit year. • speech therapists – up to a maximum of $100 per dependent child under age 17 in a benefit year • physiotherapists – up to a maximum of $10 per visit for the first 12 visits. There is no per visit maximum for additional visits during the same benefit year.	

	• naturopaths – $10 per visit for the first 12 visits per benefit year, up to a maximum of $200 per person per benefit year and $500 per family per benefit year. There is no per visit maximum for additional visits during the same benefit year.	
	• acupuncturists – up to a maximum of $100 per person per benefit year • podiatrists or chiropodists – $10 per visit for the first 12 visits per benefit year, up to a maximum of $200 per person per benefit year and $500 per family per benefit year. There is no per visit maximum for additional visits during the same benefit year. • chiropractors – $10 per visit for the first 12 visits per benefit year, up to a maximum of $200 per person per benefit year and $500 per family per benefit year. There is no per visit maximum for additional visits during the same benefit year.	
Maximum benefit	Lifetime maximum benefit – $25,000 per person	Out-of-Canada emergency services – Lifetime maximum of $500,000 per person All other expenses – Lifetime maximum of $500,000 per person
Changes in options	If you elected Extra Option at the time of your retirement, you can decrease your coverage to Basic Option at any time. If you elected Basic Option at the time of your retirement, you can only increase to Extra Option if you had comparable coverage at the time of retirement which has since been lost. Coverage begins on the first day after the other coverage ends as long as the request for coverage is received within 60 days after the other coverage has ended.	
Termination	When the pension payments from your employer cease	

Dental Health Spending Account **150533**

Benefit year	January 1 to December 31
Credits	As described under *Credits* in the Dental Health Spending Account
Eligible expenses	Expenses that are considered eligible dental expenses under the Income Tax Act (Canada) and are not paid, or not paid in full, under your group plan, your spouse's plan or any government-sponsored plan
Termination	When the pension payments from your employer cease

Life

Employee Basic Life – Contract Number 101833

Amount	
At retirement	1 times your annual basic earnings for which you were covered on the day preceding your retirement, rounded to the next highest $500
First anniversary of retirement	80% of the amount of coverage in effect on the date of your retirement

Second anniversary of retirement	60% of the amount of coverage in effect on the date of your retirement
Third anniversary of retirement	40% of the amount of coverage in effect on the date of your retirement
Fourth anniversary of retirement	20% of the amount of coverage in effect on the date of your retirement
Fifth anniversary of retirement	$1,000

Employee Optional Life – Contract Number 101933

Amount	The amount for which you were covered on the day preceding your retirement. You may maintain or decrease the amount of coverage at retirement. Maximum – $250,000
Termination	The last day of the month in which you reach age 65

Spouse Optional Life – Contract Number 101933

Amount	The amount for which your spouse was covered on the day preceding your retirement. You may maintain or decrease the amount of coverage at retirement. Maximum – $250,000
Termination	The last day of the month in which you reach age 65

Child Optional Life – Contract Number 101933

Amount	If you are covered for at least $20,000 of Employee and/or Spouse Optional Life combined – the amount for which you were covered on the day preceding your retirement. You may maintain or decrease the amount of coverage at retirement. Maximum – $2,000 per child
Termination	The last day of the month in which you reach age 65

Making Claims

There are time limits for making claims. You can find more on these time limits in the following chart. **If you fail to meet these time limits, you may not be entitled to some or all benefit payments**.

To assess a claim, Sun Life may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information Sun Life needs.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Complete the forms that are available on our website. Visit www.mysunlife.ca You can also submit claims for some expenses electronically.	Up to the earlier of the following dates: • 12 months after the date you incur the expenses, or • 90 days after the end of your Extended Health Care coverage.
Emergency Travel Assistance	Contact Sun Life's Emergency Travel Assistance provider to notify them that a medical emergency exists.	**Having expenses reimbursed:** To have services or supplies reimbursed that either you or another covered person have paid for, proof of the expenses must be provided to us within 30 days of the person's return to British Columbia Refer to *Reimbursement of expenses* under the *Emergency Travel Assistance* section for further details.
Dental Health Spending Account	Get the form on our website (www.mysunlife.ca) or call us at 1-800-361-6212. You can also submit claims for some expenses electronically.	Up to 90 days after the earlier of the following dates: • the end of the benefit year during which the expense is incurred, or • the end of your Dental Health Spending Account coverage.
Life coverage	Ask your employer to provide the claim forms.	We must receive the claim form as soon as possible after the death occurred.

General Information

The information contained in this section applies only to benefits for which Sun Life Assurance Company of Canada is the insurer or plan administrator.

The information in this retiree benefits booklet is important to you.
BC Hydro presently provides a post-retirement program called the *British Columbia Hydro and Power Authority Post-Retirement Non-Pension Benefit Plan ("Plan").* In order to implement this Plan, BC Hydro has entered into contracts with Sun Life. This booklet summarizes the terms of the coverage provided under those contracts but does not create any new rights. If there is any discrepancy between the terms of this booklet and the terms of the contracts, the terms of the contracts will prevail.

Your group benefits may be amended or terminated after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Call 604-694-8600 or 1-800-663-1339 (toll free in BC).

Your group benefits	The contract holder, British Columbia Hydro and Power Authority self-insures the following benefits:
	• Extended Health Care
	• Dental Health Spending Account
	This means British Columbia Hydro and Power Authority 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.
Classes	This booklet describes the coverage for the following classes of retirees: • Class A – MoveUp (COPE) & IBEW Retirees - Basic Option • Class B – MoveUp (COPE) & IBEW Retirees - Extra Option
Who is eligible to receive benefits?	To be eligible for group benefits, you must meet all the following conditions: • you must have been covered under your employer's group plan on the day preceding retirement. • you must have at least 10 years of service with your employer. • you must be eligible for an immediate pension from your employer. • for Extended Health Care, you must be a resident of British Columbia and entitled to benefits under the Medical Services Plan of British Columbia and registered with the Fair PharmaCare program. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent. If you or one of your dependents ceases to be eligible for Extended Health Care because you or one of your dependents are no longer a resident of British Columbia or entitled to benefits under the Medical Services Plan of British Columbia and once again becomes a resident of British Columbia, entitled to benefits under the Medical Services Plan of British Columbia and registered with the Fair PharmaCare program, you or one of your dependents may be re-enrolled for coverage under this plan within 60 days of meeting these eligibility requirements.

Who qualifies as your dependent	Your dependent must be your spouse or your child. In addition, for Extended Health Care, your dependent must be a resident of British Columbia and entitled to benefits under the Medical Services Plan of British Columbia and registered with the Fair PharmaCare program.
	Your spouse qualifies as your dependent if they are your spouse in one of the following ways: • by marriage, unless you and your spouse have been separated for 12 months or more • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least the last 12 months You can only cover one spouse at a time. **Your children and your spouse's children** (other than foster children) are eligible dependents if they are under age 21 and do not have a spouse. For Child Optional Life, a child who is a full-time student until age 25 is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse. For all other benefits, a child who is a full-time student is also considered an eligible dependent as long as the child is dependent on you for financial support and does not have a spouse. **If a child becomes disabled before the maximum age** and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Contact BC Hydro for more on this at 604-694-8600 or 1-800-663-1339 (toll free in BC).**
When coverage begins	Your coverage begins on the date you become eligible for coverage. A dependent's coverage begins **on the later of** the following dates: • the date your coverage begins. • the date you first have a dependent.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to BC Hydro at 604-694-8600 or 1-800-663-1339 (toll free in BC): • change of dependents. • change of name. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • your enrolment form or application for insurance. • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-800-361-6212.

When coverage ends	Your coverage will end on the earlier of the following dates: • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends.
	A dependent's coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage. The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

If you die while covered by this plan

Coverage for your dependents will continue until **the earlier of** the following dates:

- if your spouse is eligible for a survivor pension from your employer, the date which the survivor pension ends.
- If you do not have a spouse, or your spouse is not eligible for a survivor pension from your employer, the last day of the 2nd month following your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date your coverage would have terminated if you were still alive.
- the date the benefit provision under which the dependent is covered ends.

For Extended Health Care, your dependents will continue to be covered for the option of coverage in effect on the date of your death, unless your spouse elects to reduce coverage from Extra to Basic.

When dependent coverage continues, it is subject to all other terms of the plan.

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

Legal actions for insured benefits

Limitation period for Ontario:

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

Limitation period for any other province:

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

Legal actions for self-insured benefits

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

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total actual expenses.

However, when you have more than one plan, industry standards decide which plan you should claim expenses from first.

Please send in claims for you and your spouse in the following order:

- First, send in the claim to the plan where the person is covered as an employee. If the person is an employee under two plans, send the claim to your different plans in the following order:
  - to the plan where the person is covered as an active full-time employee.
  - then, to the plan where they are covered as an active part-time employee.
  - then, to the plan where they are covered as an employee.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

- First send the claim in to the plan where the child is covered as an employee.
- Then, to the plan where they are covered under a student health or dental plan through their educational institution.
- Then, to the plan of whichever parent has 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.

When you send us a claim, you must tell Sun Life about all other equivalent coverage that you or your dependents have.

Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefit.

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us.
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

Here are the definitions of some terms that appear in this retiree booklet. Other definitions that describe specific benefits 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.

Extended Health Care

Plan administrator

This benefit is administered by Sun Life Assurance Company of Canada.

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 dependents covered for Extended Health Care benefits.

Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed. However, there are additional eligibility requirements that apply to drugs (see *Prior authorization program* for details).

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required for treating an illness according to Canadian medical standards.

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

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

When is an expense incurred	You incur an expense on the date you receive the service or purchase or rent supplies. You must claim any expense for the benefit year in which you incur the expense. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Deductible, reimbursement level and maximum benefit	The deductible is the portion of claims that you are responsible for paying. After the deductible has been paid, claims will be paid up to the reimbursement level and maximum benefit under this plan. **For each type of service listed below, the deductible and the reimbursement level are indicated in the Benefit Summary. The maximum benefit for all expenses combined is also indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 100 day period.
What is not covered	We will not pay for the following, even when prescribed: • vaccines. • contraceptives. • 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. • 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) except otherwise provided under the list of eligible expenses specified in the Benefit Summary. • 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.
Prior authorization program	The prior authorization (PA) program applies to a limited number of drugs, where you must get approval in advance for coverage under the program. In order for drugs in the PA program to be covered, you need to provide medical information. Please use our PA form to submit this information. Both you and your doctor need to complete parts of the form. You will be eligible for coverage for these drugs if the information you and your doctor provide meets our clinical criteria based on factors such as: • Health Canada Product Monograph. • recognized clinical guidelines. • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • your response to preferred drug therapy. If not, your claim will be declined. See *How to Connect with Sun Life Financial* at the beginning of this booklet for information on how to obtain our prior authorization forms.

Hospital expenses in your province

Hospital	We will cover the cost of room and board in a hospital in the province where you live, as indicated in the Benefit Summary. 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.
Convalescent hospital	We will cover the cost of room and board in a convalescent hospital, as indicated in the Benefit Summary, if this care has been ordered by a doctor as long as it is primarily for rehabilitation, and not for custodial care.
	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.

Expenses out of your province

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, the reimbursement level is indicated in the Benefit Summary.** For both emergency services and referred services, we will cover the cost of: • a semi-private room, outside of Canada only • other hospital services provided outside of Canada • out-patient services in a hospital • the services of a doctor Hospital room and board expenses are limited to a maximum of 90 days unless transportation would endanger the life of the patient.
Emergency services	We will only cover emergency services obtained within the time limit indicated in the Benefit Summary. 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 treatment program that existed before they left their home province. *Emergency* means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor. **Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away. Sun Life's ETA provider must approve all invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan) before you have them.
	If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.

	In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. An emergency ends when Sun Life's ETA provider, based on available medical evidence, deems you 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 Sun Life's ETA provider, 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. • services incurred as a result of pregnancy, miscarriage, child birth or complications of any of these conditions occurring within 4 weeks of the expected date of delivery.
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. 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. However, if referred services are not available in Canada, they may be obtained outside of Canada.

Travel for medical care for persons who reside in British Columbia

Travel for cancer treatments	We will cover the cost for round trip transportation by automobile, scheduled air travel, rail, bus or ferry between your city of residence and the nearest cancer clinic within British Columbia or Alberta (or any other locale designated by the Plan Sponsor) equipped to provide the required treatment. Where transportation is provided by automobile: • the maximum amount payable is $0.475 per kilometre. • round trip distance must exceed 300 kilometres*. • gasoline receipts are not required. *If you reside in an eligible remote community, the 300 kilometre round trip minimum does not apply.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private-duty nurse	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor 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 cannot perform the duties	
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary For Class B (Extra Option) – Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency expenses* and *Maximum benefit*	
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary For Class B (Extra Option) – Expenses incurred outside Canada for emergency services will be paid based on the conditions that appear in the Benefit Summary for *Out-of-province emergency expenses* and *Maximum benefit*	

Covered expenses	Details	Payment limits
Dental services following an accident	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 You must receive these services within 12 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the retiree lives
Wigs	After chemotherapy	$100 per person in any 12 month period. Only dependent children under age 21 are covered for these items
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription 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, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses or crutches		
Knee scooters		$500 per person over 5 benefit years
Splints or braces	Must be prescribed by a doctor	
Breast prostheses	Required as a result of surgery	$200 per person per benefit year
Surgical brassieres	Required as a result of surgery	$150 per person per benefit year
Artificial limbs and eyes		
Stump socks		$200 per person per benefit year
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	
Custom-made orthotics for shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair per person per benefit year
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	1 pair per person per benefit year
Hearing aids		$300 per person over 5 benefit years Repairs are included in this maximum Only dependent children under age 21 are covered for these items
Oxygen		

Covered expenses	Details	Payment limits
Blood glucose monitors and continuous glucose monitors and their receivers, transmitters and sensors		
Insulin pumps	Must be prescribed by a doctor	
Speech aids	Must be prescribed by a doctor	1 per person over 5 benefit years
Constant positive airway (CPAP) machine	CPAP machines requiring replacement within 5 years from the last purchase will require pre-approval In order to approve replacement, we will require documentation from the supplier to confirm if the current unit can be repaired as well as the cost of the repair If repair is available, then the unit cannot be replaced during the 5 year period from initial purchase Must be prescribed by a doctor	$2,600 per machine and $350 per mask limited to 2 masks per person in a benefit year
Colostomy supplies		
Living aids		
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary

Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Qualified paramedical practitioners must:

- belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us,
- be licensed or registered, as required by the applicable provincial regulatory body,
- have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered,
- maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association,
- produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and
- not engage in administrative practices unacceptable to us.

This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.

If you recover damages from another person

The contract holder has the right to part of any money you recover through legal action or settlement from another person, organization or company who caused you to incur medical expenses.

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

If you recover money, you must pay us, for the benefit of the contract holder, the amount by which the sum of the benefits paid under this plan and your net recovery exceeds 100% of the actual cost of the medical expenses for which benefits were paid.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

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*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- 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.

Integrating this plan 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 your employer's plan is the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

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 dependents covered for Emergency Travel Assistance benefits.

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

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

The emergency services excluded from coverage, and all other conditions including maximums, limitations and exclusions that apply to your Extended Health Care coverage also apply to Medi-Passport.

Bring your Travel card with you! There you will find telephone numbers and the information you'll need to confirm your coverage and get help.

Getting help	**Contact us right away in an emergency!** You or someone with you must contact Sun Life's Emergency Travel Assistance (ETA) provider right away.
	If Sun Life's ETA provider does not hear from you first, before you receive emergency services, and we determine that someone could have reasonably made contact on your behalf, Sun Life has the right to deny or limit payments for all expenses related to that emergency.
	In extreme circumstances where contact with Sun Life's ETA provider cannot be made before services are provided, you must contact Sun Life's ETA provider as soon as possible afterwards. Access to a fully staffed coordination centre is available 24 hours a day. Please consult the telephone numbers on the Travel card. Sun Life's ETA provider may arrange for:
On the spot medical assistance	Sun Life's ETA provider will provide referrals to physicians, pharmacists and medical facilities. As soon as Sun Life's ETA provider is notified that you have a medical emergency, its staff, or a physician designated by Sun Life's ETA provider, 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, Sun Life's ETA provider will also guarantee or advance payment of the expenses incurred to the provider of the medical service. Sun Life's ETA provider will provide translation services in any major language that may be needed to communicate with local medical personnel. Sun Life's ETA provider will transmit an urgent message from you to your home, business or other location. Sun Life's ETA provider will keep messages to be picked up in its offices for up to 15 days.

Transportation home or to a different medical facility	Sun Life's ETA provider 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, Sun Life's ETA provider will arrange, guarantee, and if necessary, advance the payment for your transportation. Sun Life or Sun Life's ETA provider, 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.
Meals and accommodations expenses	If your return trip is delayed or interrupted due to a medical emergency or the death of a person you are travelling with who is also covered by this benefit, Sun Life's ETA provider will arrange for your meals and accommodations at a commercial establishment. We will pay a maximum of $150 a day for each person for up to 7 days. Sun Life's ETA provider will arrange for meals and accommodations at a commercial establishment, if you have been hospitalized due to a medical emergency while away from the province where you live and have been released, but, in the opinion of Sun Life's ETA provider, are not yet able to travel. We will pay a maximum of $150 a day for up to 5 days.
Travel expenses home if stranded	Sun Life's ETA provider will arrange and, if necessary, advance funds for transportation to the province where you live: • for you if, due to a medical emergency, you have lost the use of a ticket home because you or a dependent had to be hospitalized as an in-patient, transported to a medical facility or repatriated (sent home); or • **for a child** if, due to a medical emergency, you need to be admitted to hospital and they are left unattended while travelling with you outside the province where you live. We provide this benefit for children who are under 16 or mentally or physically handicapped. If necessary, in the case of such a child, Sun Life's ETA provider will also make arrangements and advance funds for a qualified person to go home with the child as their attendant. We will pay a maximum of the cost of the transportation minus any redeemable portion of the original ticket.
Travel expenses of family members	Sun Life's ETA provider will arrange and, if necessary, advance funds for one round-trip economy class ticket for a member of your immediate family to travel from their home to the hospital where you are: • if you are there for more than 7 days in a row, and • if you are travelling alone or you are travelling only with a child who is under 16 or mentally or physically handicapped. We will pay up to $150 a day for the family member to eat and stay at a commercial establishment up to 7 days.
Returning you home (repatriation)	If you die while out of the province where you live, Sun Life's ETA provider will pay up to $5,000 to do the following: • arrange for all necessary government authorizations. • arrange for the return of your remains in an approved container.

Returning your vehicle	Sun Life's ETA provider will arrange and, if necessary, advance funds up to $500 to return a private vehicle to the province where you live or a rental vehicle to the nearest appropriate rental agency if death or a medical emergency prevents you from doing so.
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, Sun Life's ETA provider will direct you in how to arrange for replacement of travel documents or who to contact about your lost or stolen luggage. This is a service only. There is no benefit amount payable in the event of lost or stolen luggage or documents.
Limits on advances	Advances will not be made for requests of less than $200. Requests in excess of $200 will be made in full up to a maximum of $10,000.
Reimbursement of expenses	If you obtain confirmation from Sun Life's ETA provider that you are covered and a medical emergency exists, Sun Life will reimburse you for services and supplies that you paid for and that are covered by this plan. In this situation, you should do the following: • keep the receipts. • always obtain a fully itemized bill for any hospital treatment. • within 30 days of your return home, complete an Extended Health Care claim form, include original receipts and any itemized bills, and send directly to Sun Life's ETA provider. Sun Life's ETA provider's address can be obtained by visiting our Sun Life Financial Plan Member Services website at www.mysunlife.ca or by calling our Sun Life Financial Customer Care centre toll-free number 1-800-361-6212. Sun Life's ETA provider will ask you to sign a form authorizing them to act on your behalf with your provincial medicare plan. You must sign and return this form to Sun Life's ETA provider before your claim can be processed.
Coordination of coverage	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.
Your responsibility for advances	You will have to reimburse Sun Life for any of the following amounts advanced by Sun Life's ETA provider: • 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.
Limits on Emergency Travel Assistance coverage	There are countries where Sun Life's ETA provider is not currently available for various reasons. For the latest information, please call Sun Life's ETA provider before you leave on your trip.

	Sun Life's ETA provider 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, terrorism or an act of God. • the refusal of authorities in the country to permit Sun Life's ETA provider to fully provide service to the best of its ability during any such occurrence.
Liability of Sun Life or Sun Life's ETA provider	Neither Sun Life nor Sun Life's ETA provider will be liable for the negligence or other wrongful acts or omissions of any physician or other health care professional providing direct services covered under this group plan.

Dental Health Spending Account

General description of the coverage

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

In this section, *you* means the retiree and all dependents covered for Dental Health Spending Account benefits.

Your Dental Health Spending Account coverage provides reimbursement to you for services or supplies described in this section under *Eligible expenses*.

An expense is incurred on the date the services are received. Coverage applies only to eligible expenses incurred after you become covered under the Dental Health Spending Account and before the date the Dental Health Spending Account ends.

A dependent is your spouse, your children or any other person whom you may claim as dependents under the Income Tax Act (Canada). For example, this could include members of your extended family, such as your parents, grandparents or grandchildren. You can claim eligible expenses for dependents even if they are not covered under your Extended Health Care benefit.

The benefit year is indicated in the Benefit Summary.

How your Dental Health Spending Account works	Your Dental Health Spending Account works like an expense account. Your employer will allocate credits to your account in the manner described under *Credits*.
	Each time you submit a Dental Health Spending Account claim, either for yourself or for a dependent, you will be reimbursed for eligible expenses described in this section under *Eligible expenses*, up to the balance of your Dental Health Spending Account.
Plan with no carry-forward feature	Any credits remaining in your Dental Health Spending Account at the end of a benefit year will be lost. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Credits	$250 at the beginning of each benefit year
Eligible expenses	You can use your Dental Health Spending Account to cover dental expenses that are eligible under the Income Tax Act (Canada) and are not paid, or not paid in full, under your group plan, your spouse's plan or any government-sponsored plan. Eligible expenses include but are not limited to the items listed below: • portion of dental expenses not covered by a health or dental benefits plan such as deductibles, coinsurances or amounts over plan maximums. • premiums for dental benefits. • services performed by a qualified dental practitioner. *Qualified* means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Other coverage

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

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

Life Coverage

Insurer

This benefit is insured by Sun Life Assurance Company of Canada.

General description of the coverage

BC Hydro pays the premiums for your Basic Life benefit and will include these premiums as a taxable benefit on your tax slips.

Your Life coverage provides a benefit for your beneficiary if you die while covered. Your dependents' Life coverage provides a benefit if one of your dependents dies while covered.

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

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 your employer. If you have not named a beneficiary, we will pay the benefit amount 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 dependent dies, Sun Life will pay you the benefit for that dependent. **Fact** There are different rules for designating a minor beneficiary, please refer to your contract for specific information.
Suicide	If you or your spouse have any optional coverage that has been in effect for less than 2 years, we will not pay benefits if death is by suicide, regardless of whether you or your spouse have a mental illness or intend or understand the consequences of your actions.

Converting Life coverage

If your Life coverage or your spouse's Life coverage ends or reduces for any reason other than your request, you or 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 because your Life coverage has ended, 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 that the Life coverage reduces or ends.

Important
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.

Retiree Additional Information

The following information is provided by BC Hydro. This coverage is provided and administered by BC Hydro. Sun Life does not provide any services in connection with this coverage.

Medical Services Plan of BC (MSP)

The Government of BC eliminated MSP premiums effective January 1, 2020.	If you're eligible for post-retirement benefits, BC Hydro enrol you and your eligible dependents under our MSP group account (4009338) for administration purposes.
Who is an eligible dependent for MSP?	For MSP, eligible dependents include: *Your spouse:* • legally married or • the person who you have been living in a common-law relationship for at least one year and publicly represented as your spouse. A divorced or common-law spouse that you no longer live with is NOT eligible for coverage as a dependent. *Your dependent child(ren):* A child, stepchild, legally adopted child or legal ward who is: • financially dependent on you; • unmarried; and • under age 19 ***or*** under age 25 if attending school or university full time
Who to contact if your dependents change?	You are responsible for reporting any change in dependents to BC Hydro within 31 days of the change by calling 604-694-8600 or 1-800-663-1339 (toll free in B.C.)

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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).

Life’s brighter under the sun

Group Benefits are provided by Sun Life Assurance Company of Canada,
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